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Ladnaan
Evaluation of a Culturally Tailored
Parenting Support Program to Somali-born
Parents

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Ladnaan – Evaluation of a Culturally Tailored Parenting Support Program to Somali-born Parents

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This thesis is dedicated to my beloved mother Nura and to the memory of my father Ahmed, who gave me a solid foundation – a foundation of unconditional love, warmth, encouragement, autonomy and resilience which was essential for my future life to build upon. I would also like to dedicate this thesis to the memory of my best friend and little brother Osman; together, we crossed borders and countries. Sadly, both you and dad left this world early but the memories of you kept me moving forward, may Allah grant you Jannah.

ABSTRACT

Background: Research shows that immigrant families encounter different complexities and challenges in a new host country, such as acculturation, isolation and lack of social support. These challenges have been shown to have negative impacts on immigrant families' mental and emotional health, family function, parenting practices and parents' sense of competence. Parental support programmes have been shown to positively affect parental skills, strengthen the parent-child relationship, and promote the mental health of parents and children.

However, universal parenting support programmes face challenges in reaching and retaining immigrant parents. In addition, there is limited knowledge on the effectiveness of parenting support programmes among immigrant Somali-born parents and their children.

Aim: The overall aim of this thesis was to develop and evaluate the effectiveness of a culturally tailored parenting support programme (Ladnaan intervention) on the mental health of Somali-born parents and their children. A further aim was to explore the parents' experience of such a support programme on their parenting practises.

Methods: The thesis involved two explorative qualitative studies and one randomised controlled trial (RCT). Study I employed qualitative focus group discussions (FGDs) to explore Somali-born parents' need for parenting support. Study II involved an RCT study in which 120 parents with children aged 11–16 years, and parents with self-perceived stress relating to their parenting were randomised to an intervention group or a wait-list control group. The Ladnaan intervention consisted of three components: societal information (two sessions), the Connect parenting programme (10 sessions), and a cultural sensitivity component. The Ladnaan intervention was delivered in the participants' native language by group leaders of similar background and experience, and modifying the examples and role plays in the Connect programme. The primary outcome was a reduction in children's emotional and behavioural problems as measured by the Child Behaviour Checklist 8-16. The secondary outcomes were improved mental health among parents, as assessed by the General Health Questionnaire (GHQ12); and greater sense of parenting competence, as measured by the Parent Sense of Competence (PSOC) scale. Study III comprises a qualitative study using individual semi-structured interviews (conducted two months after the Ladnaan intervention) to explore parents' experiences of participating in a culturally tailored parenting support programme.

Results: The results in study I, shows that Somali-born parents encountered challenges in the host country, which impacted their confidence in parenting and the parent-child relationship. These challenges included insufficient knowledge of the parenting system and social obligations as a parent in the new host country. Other parental challenges in the host country included a stressful society, isolation, role changes, and parent-child power conflict. The Somali parents experienced opportunities to rethink and modify their parenting and strengthen their relationship with their children in the new country, but needed support from the local authority and others in these endeavours. In study II, the Ladnaan intervention showed that, according to the parents' self-reports, children in the intervention group showed significantly decreased aggressive behaviour, social problems, attention problems,

externalising of behavioural problems, and in total problems at the two-month follow-up. Moreover, parents in the intervention group showed significantly and clinically improved mental health and sense of competence in parenting at the two-month follow-up. The improved mental health of the parents could, in part, be explained by their satisfaction in parenting. In study III, parents who participated in the culturally tailored intervention programme reported that it enhanced their confidence in parenting and contributed to their ability to become emotionally aware and available for their children. The parents attributed this to the combination of societal information, the Connect programme, and the cultural sensitivity of the Ladnaan intervention, which were most supportive for their parenting. The culturally sensitive approach of the parenting programme (i.e., conducted in their native language by bicultural and bilingual group leaders) was viewed by the parents as valuable for their participation in the programme, as well as for modifying their parenting practices.

Conclusion: The culturally tailored parenting support programme helped parents overcome transition challenges related to social obligation as parents in the host country, and to modify their parenting orientation and styles in the new country. Furthermore, it improved the parents' mental health and sense of competence in parenting, as well as reduced their children's behavioural problems. When tailoring and delivering a parenting support programme to immigrant parents it is crucial to consider their specific needs and preferences and to ensure that the programme is culturally sensitive. Such an approach is more likely to contribute to participants' engagement, retention, and acceptance of the parenting programme; and also improve their parenting practices and strengthen parent-child relationship, leading to improvements in children's behaviour and parents' mental health.

Keywords: acculturation, behaviour problems, emotional problems, children, culturally tailored, culturally sensitive, migration, mental health, parenting, parent-child relationship, parent sense of competence, parental support, qualitative, RCT, Somali-born parents.

LIST OF SCIENTIFIC PAPERS

- I. Osman, F. Klingberg-Allvin, M., Flacking, R., Schön, U-K. Parenthood in Transition – Somali-born Parents' Experiences of and Needs for Parenting Support Programmes. BMC Int Health Hum Rights. 2016, 16:7. doi:10.1186/s12914-016-0082-2
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- IV. Osman, F., Flacking, R., Klingberg-Allvin, M., Schön, U-K. Somali parents' experiences of participating in a culturally tailored parenting support program in Sweden. *Manuscript*.

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LIST OF ABBREVIATIONS

ANCOVA	Analysis of Covariance
CBCL	Child Behaviour Checklist
CI	Confidence Interval
CRC	Convention on the Rights of the Child
FGD	Focus Group Discussion
GHQ	General Health Questionnaire
PSOC	Parent Sense of Competence
RCI	Reliable Change Index
RCT	Randomised Controlled Trial
SD	Standard Deviation
WHO	World Health Organisation

DEFINITIONS OF CENTRAL TERMS

Culture refers to commonly understood, learned and shared values, beliefs and traditions that are passed on from one generation to another through social interaction [1].

Cultural parenting orientations refers to parents' cultural beliefs, attitudes and values on how to be a good parent and how the child should behave according to the parents' beliefs and values [2].

Cultural sensitive alludes to the extent that the target group's culture, language, experiences incorporated in the design, delivery and evaluation of the intervention [3].

Cultural tailoring is defined as the process to develop and adapt culturally sensitive interventions or health promotion programmes for ethnic subgroups [3]. In this thesis refers to the socially relevance and cultural sensitivity strategies in parenting support programme to meet the specific need of the targeted population.

Ethnicity is a social classification based on a sense of belonging to a group that share origins, social background, culture, traditions and language. It is the person itself who attributes to an ethnic belonging [4].

Externalising problems denotes to children's external behaviour, such as aggression, delinquency and anti-social behaviour.

Forced migration is an involuntary migration and refers to a person's internal or external displacement from his or her country of residence because of fear of persecution, natural disaster or environmental disaster [5].

Health is defined according to the World Health Organisation (WHO), as a "*state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living, and is a positive concept emphasising social and personal resources as well as physical capabilities*" [6].

Internalising problems refer to the internal stresses such as anxiety, depression, social withdrawal, and somatic complaints.

Mental health is defined according to the WHO as a "*state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to contribute to his or her community*" [7].

Mental health problems among children are defined by two broader dimensions, namely, externalising and internalising problems.

Migration is most commonly used and defined as the movement of a person from one country to another on a permanent or semi-permanent basis, regardless of the root cause. The definition includes refugees, forced migration, labour migrants or family reunification. In this thesis, it is the involuntary migration, i.e. forced migration that is of interest and refers to migration.

Parent refers to the guardian of the child with which the child is permanently living.

Parenting efficacy is parents' belief in, and perceptions of, their ability to perform their parenting successfully.

Parenting satisfaction is defined as "*a sense of pleasure and gratification regarding the parenting role*" [8].

Parenting sense of competence includes both parenting efficacy and satisfaction.

Parenting support is defined as “an activity that gives parents knowledge of children’s health, emotional and cognitive as well as social development and strengthens parents’ social networks” [9, p.4].

Parenting styles describes parents’ child-rearing practises and how parent and child socialise and interact with each other [2]. Baumrind identified three parenting typologies as [10]:

Authoritative parenting: characterised by a democratic parenting style in which parents give parental warmth, emotional support, and autonomy to their child.

Authoritarian parenting: characterised by parents’ attempts to shape, control, and discipline their child as well as to demand the total obedience of their child.

Permissive parenting: characterised by parents’ lack of, or fewer, demands on, the child.

Neglectful parenting: developed by Maccoby et al. [11], it is characterised by low demands and responsiveness to the child’s needs.

Refugee is defined according to the Geneva Convention [12] as a person who is forced to be outside his or her country and is afraid or unable to return back because of fear of persecution based on race, religion, or political opinions.

PREFACE

War salaadu halkeey iska qaban la'dahay?

What is wrong with the prayer? (i.e. what is causing the misunderstanding and the chaos?)

The Somali wisdom quoted above is the question that was raised after my meetings with Somali parents and their children from my years of working as a Somali interpreter in different settings (i.e. health care and social services), and later when I was interviewing Somali parents for my master's thesis. I met many families (parents and their children), who stressed their acculturation challenges in the new host country: the acculturation gap between parents themselves, and between parents and children. Parents were frustrated and complaining that the children were not understanding them, and children in turn complained that their parents were not understanding them. This was the starting point of my interest in the topic of parenting support as investigated in this thesis.

Parents shared their stories about how the acculturation challenges led to a loss of confidence in their parenting; they also felt that they were not supported by the authorities, i.e. the social and healthcare systems. Some of the parents even regretted leaving their home country and wanted to return. During my meetings with children and young people through activities and workshops in Somali associations, the children shared their belief that neither their parents nor the society understood them and their needs. At that time, I did not have any tools and did not know how to give support and thus the encounters left me with lots of unanswered questions. I also noticed that the parents were often offered support during pregnancy and the child's first year through maternal and child health care, but they lacked support when their children reached their preteens and teens, which is a critical time point for the parent-child relationship, even without the added acculturation challenges and gaps.

There are many experiences in my own life that I can share with both the parents and children who came here recently under stressful and difficult conditions. I came to Sweden from Somalia as a 19-year-old and I have encountered numerous challenges through my transition and acculturation process: coping with being away from family, friends, and social network, learning a new language, starting over with my life, financial difficulties, and experiencing racism and discrimination. I also became a parent in a country where I did not have the extended family network that might have guided me in my new role as a parent. Moreover, I did not have any cultural references on how to be a good parent in my new home country.

A starting point of this thesis was therefore the belief that by providing parenting support, one need to be able first to identify, describe and understand the parents' need of support in their parenting, and then this knowledge can be applied in the planning and the development of the support programme. In practice, I have experienced that we often assume to understand rather than assess the individual's need of support, and then we wonder why we failed.

1 INTRODUCTION

The point of departure for this thesis is the data demonstrating that forced migration has had a strong influence on the social and health outcomes of immigrants. Pre-migration factors (i.e. war, violence, trauma), migration, the journey from the home country to the destination country and post-migration factors (e.g., acculturation, isolation, loss of societal roles, lack of social support) are associated with poorer mental health among immigrants. A combination of past trauma and stressors related to pre-migration and migration, post-migration factors were experienced by immigrants as the most challenging [13]. One of the post-migration factors identified as most challenging is the process of acculturating in the host country. This has an impact on families' health, parenting practises and parents' sense of competence. Parents' internal and external resources and family functioning are some of the factors that affect children's health, the development of diverse skills, and their cognitive, emotional, and societal development [14-16]. Parental support programmes are offered to parents as health promotion and prevention to strengthen family functioning and promote children's mental health [9].

The Swedish government has established a national strategy on parental support that aims to support parents in their parenting role and to promote positive parenting practises [9]. However, there are major challenges to engage immigrant parents in the universal parenting support programmes that are offered to the population. Furthermore, there is still limited knowledge on how to engage immigrant parents in the parental support programmes, as well as the effect of parenting support programmes delivered to immigrant parents. Thus, the focus of this thesis is a culturally tailored parenting support programme for Somali-born parents. The focus of Somali parents in this thesis was based on the need to access hard-to-reach groups in the universal parental support. One municipality in Sweden was chosen as the study setting which had the largest Somali immigrants groups. The municipality had also received several reports from the social services related to an increasing number of out-of-home placements among children originating from Somalia.

Research focusing on interventions tailored to immigrant groups might lead to stereotyping and stigma. However, the perspective of this thesis is to understand the Somali-born parents' needs on parenting routines in the new host country and tailor the parenting support programme to their unique needs. Therefore, the research process for this thesis took its starting point in exploring Somali-born parents' experiences on being a parent in Sweden and their need of parenting support (study I). Based on the findings from this first study, we could develop, implement, and evaluate the culturally tailored parenting support programme. The effectiveness of the support programme on the mental health of children and parents mental health as well as parenting sense of competence was evaluated. The children's mental health (i.e. emotional and behavioural problems) was measured from parent reports. Finally, parents' experience of the parenting support programme and which part of the intervention that had the greatest impact on their parenting was explored.

2 BACKGROUND

No one leaves home unless home is the mouth of a shark. (Somali poem by Shire, [17]).

2.1 PRE-MIGRATION, MIGRATION AND POST-MIGRATION STRESSORS

Sweden has received some of the highest numbers of asylum applicants per million inhabitants in Europe [18]. For the past decade, many people from Afghanistan, Eritrea, Iraq, Somalia and Syria have sought asylum in Sweden because of war, violence and oppression [19]. Today, 16% of the Swedish population are foreign-born [19]. Somali immigrants are one of the largest groups among African immigrants in Sweden. As of the end of 2016, there were approximately 64 000 Somali-born individuals in Sweden [20].

Forced migration influences an individual's life and health. The association between migration and health is complex, but, in general, studies have shown that the migration process, namely pre-migration, migration and post-migration stressors, may have a negative effect on immigrants' health depending on the reasons for migration [13, 21].

Pre-migration stressors for individuals who are forced to flee from their country include experiences of war, trauma and loss of family members [13, 22]. Studies have shown a clear connection between war, violence and trauma exposure and mental health problems [15, 23-25]. Migration itself can lead to difficulties depending on the circumstances in the journey, transit country, time of migration and geographical distance. The process of applying asylum, settling in the new country and family reunion might take longer time and have an impact on the individual and family's health [13, 26]. Post-migration stressors are encountered in the host country and include the asylum process and resettlement [27]. In the resettlement process immigrants may face many stressful challenges, including family separation, loneliness, lack of financial and social support, inadequate housing, acculturation difficulties and perceived racism and discrimination [15, 16, 27, 28].

Several studies have investigated the relation between post-migration factors and immigrants' mental health [14, 16, 27-29]. For example, a study conducted in Sweden [27] showed that social isolation, financial difficulties and experiences of discrimination were associated with the risk of mental health problems in the host country. Another study [14] confirms this finding, adding that poor social integration, conflicts in the family and concerns for families in the home country were also associated with an increased risk of mental health problems. Loss of identity and lack of support on integrating in the host country have also been shown to negatively affect health [16]. In contrast, the degree to which individuals are integrated with, and participate in, the host country culturally, socially and economically has a positive effect on immigrants' physical and mental health [29].

Findings from the above-mentioned studies show that several of the risk factors associated with poorer health among immigrants appear to be post-migration rather than pre-migration

factors. One factor that the studies emphasised as being important is the level of acculturation into the host country [14-16, 27-29].

2.2 ACCULTURATION AND TRANSITION INTO THE HOST COUNTRY

Immigrants typically go through a process of adjustment and transition to the host country called acculturation, which is commonly associated with complexities, challenges and opportunities [30, 31]. The acculturation process has been explained as a dual process in which immigrants orient themselves in the host country and how the host country includes and assists them in integrating into the new country [32, 33].

According to Berry [32, 33], the process of acculturation encompasses four categories of cultural adaptation: 1) Integration, in which the individual maintains both his or her original culture and the host country's culture. This process is facilitated if the host country is characterised by multiculturalism and allows the individual to practise both cultures; 2) Assimilation, in which the migrant downplays his or her culture of origin and seeks to practise only the host country's culture, and, at the same time, the host country seeks the assimilation of the individual; 3) Separation, in which the individual only seeks his or her own culture of origin and avoids interacting with the new society. This process may be developed or forced by the host country through segregation, which leads to the final category; 4) Marginalisation, the alienation of the individual from the host society. As described by Berry, it is only when the individual wishes to integrate and the host country offers multiculturalism that high acculturation occurs [33].

Depending on high and low acculturation, studies have shown how the individual's health is positively (high acculturation) or negatively (low acculturation) affected [14, 16, 29]. The more the individual perceives acceptance in the host country, the more positive the health outcome [29] and experience of acculturation [33].

2.2.1 Family acculturation and its influence on parent-child relationships

The acculturation process also occurs in the family, such as between spouses and between parents and children. This acculturation is often associated with the loss of the extended family and social network in conjunction with changes in the family dynamics [30, 31, 34]. Adjustment and transition in the host country may not occur at same time between spouses and between parents and children, which this may lead to serious consequences in family relationships [30, 31, 34, 35].

In the acculturation process, families who immigrate adapt consciously and unconsciously to the host country's culture, but parents and children's acculturation processes may occur differently [33, 36]. Children have more opportunity to acculturate in the host country through generally having a higher exposure to the environment, the media and their peers than their parents [37]. Children acculturate faster and influence their parents' practises on childrearing [38]. However, parents may also start to revise and reject some of their

parenting practises and adapt to the host country while simultaneously maintaining specific culture values that they want to pass on to their children [36, 38, 39].

The acculturation processes for parents and children often do not occur simultaneously, and acculturation conflicts can occur because of both cultural and generational changes [40]. However, this is a dynamic complexity that varies across individuals, groups and context, as well as depending on reason for migration, i.e. voluntary or involuntary migration [41, 42]. Studies show that the acculturation gap between parents and children was associated with greater conflict between them [43, 44]. Such conflicts between parents and children related most prominently to the acculturation gap rather than the generational gap, where most of parent-child conflicts concerned cultural values and attitudes [44]. The acculturation conflicts have been shown to have a negative impact on parent-child relationships [40, 41, 45]. The most common acculturation conflicts between emigrant parents and their children concern autonomy, in which children demand more independence, less parental authority in the host country and on how parents react to, and act upon, this [40, 41]. Parents' desire to grant their adolescents autonomy at a later age and the adolescents opposing this position would lead to disagreement that contributed to further conflicts between them [46]. Another acculturation gap that has had a negative impact on the parent-child relationship is children's language brokering, i.e. that children become interpreters and spokespersons for their parents [47, 48]. Roche et al.'s study [47] showed that adolescents who helped their parents in reading letters relating to bills, health matters, insurance and bank statements had less parent-child affection and trust. The parents, on the other hand, had less knowledge and authority concerning their child's behaviours.

2.2.2 Immigrant parents' experience of challenges to parenting in a new country

Several studies, though based in different countries and concern immigrant groups with different ethnicity, have addressed similar challenges that immigrant parents encounter in the host country, which affect the family functioning and parenting sense of competence [30, 31, 34, 38, 49-54]. In several studies, immigrant parents have reported a dual struggle in the host country: a struggle to adjust to the new culture and context and a struggle to acquire decent living conditions. An issue that many immigrant parents from different countries, contexts and cultures experienced was the lack of a collective society and extended family in the new country [38, 48-50, 52, 53]. The extended family in the home country supported parents with childrearing, kept the family together and all decisions around the family were made in the collective society. Most studies have emphasised this collectiveness as being positive [30, 31, 34, 38, 39, 48-51, 53, 54]. The loss of the extended family was thus a source of stress [39] and loneliness for some parents [31, 50]. Other parents, however, engaged the community and non-family members when needing support to deal with their children [34].

Immigrant parents from Africa and South Asia, whose cultures are characterised by a collectivistic orientation, stressed that their parenting orientation and styles conflicted with the host country's individualistic orientation on parenting [34, 51]. A common perceived understanding that immigrant and refugee parents from East Africa, South Asia and Middle East held was that the law and authority in the new country supported children's demands of independence, which undermined the authority of the parents [31, 34, 38, 39, 49, 52-54]. Parents in these studies felt a sense of powerlessness and lack of control of their children, which led to many of the children becoming engaged in delinquent behaviours. Children, on the other hand, disengaged from their parents and rejected parents' cultural values, which parents perceived as a lack of respect. Thus, tension between parents and children was inescapable [34, 38, 49, 52, 54]. Immigrant parents who originated from the Middle East, Somalia and South Asia were familiar with institutions that did not intervene in parents' capability to parent [38, 51, 54]. Thus, the involvement of authorities in the new country in matters concerning their children frightened most of these parents, particularly concerning the authorities' power to relocate children [51-54]. Somali parents perceived that the authorities, particularly social workers, did not provide support but rather judged and mistrusted them [39, 53, 54]. Low self-efficacy in parenting and the lack of abilities to employ positive parenting practises were reported by immigrant parents [30, 31, 34, 49, 54]. Conversely, immigrant parents who were acculturated were shown to have confidence in their parenting and employed positive parenting practises [55].

Changes in gender roles between spouses was another challenge that immigrant parents from different countries and different ethnicities encountered in the host country which contributed to changes in the family dynamics [30, 31, 38, 39, 53, 54]. Women carried the burden of working both in- and outside the home and lacked the support of the extended family [34, 38]; men felt a loss of authority within the family [38, 53]. However, changes in gender roles also contributed to a positive family structure among immigrants from Somalia and Sudan, in which fathers were more involved in household and childrearing responsibilities [30, 39].

Findings from the above studies revealed that immigrant parents from different ethnicities, who immigrated to different countries such as Finland, the UK, the USA, Australia and New Zealand shared similar experiences and challenges concerning their parenting in the new country. In these different countries, parents stressed a need for support in improving parent-child relationships, along with knowledge of parenting skills and strategies in the host country. They emphasised a need for culturally sensitive support [30, 31, 34, 49], as well as social support in social gatherings for parents [31].

2.2.3 Risk factors for children's mental health

Several risk factors are associated with Somali and Asian immigrant children's mental health problems in the Western world, such as acculturation problems, parent-child conflicts due to cultural changes and the parenting styles used by the parents [56-59]. In this regard, there is a strong association between the level of integration into the host country

and their children's behavioural problems in Asian parents [57]. The acculturation gap (particularly maternal acculturation) between parents and children has been associated with a negative child outcome [43]. Immigrant parents from Somalia and China who felt integrated in the host country reported fewer behavioural problems in their children [56, 58]. Studies report that Somali adolescents who experienced being more acculturated than their parents (e.g., being the link between the host country and their parents) were at risk of mental ill-health [59] caused by disharmony and power conflicts [60]. Moreover, the lack of belonging to either their original culture/community or the host culture/community had a negative effect on Somali adolescents' mental health [59]. Somali adolescents' own acculturation obstacles (such as perceived discrimination) were also associated with emotional and psychological difficulties [61, 62].

In general, parents' mental health has been shown to have an impact on children's mental health [63, 64]. Parents' experiences of war, recent stressful events in the family (e.g., death of parents, divorce, a parent admitted to psychiatric care) [65-67] and maternal mental ill-health and psychological ill-being also had a negative effect on children's mental health [68, 69], which would affect the parent-child relationship [63, 64, 70]. Parents' mental health problems were associated with a low perceived sense of competence in parenting, which may have an impact on parenting styles and practises [71, 72]. A study conducted in the Netherlands with Moroccan immigrant parents showed that parents' use of authoritarian parenting was related to externalising problems in children [73]. The conflict and disrupted family cohesion between parents and children from Asia were related to depressive symptoms, along with externalising and internalising problems in children [74, 75]. Negative parenting practises and parent-child conflict have been shown to predict more health problems among children [76]. Research has also reported that immigrant families where there is a lack of parent-child communication, family conflicts and high parental control aggravate the parent-child relationship, which led to negative parenting practise and emotional problems in children [77].

2.3 POSITIVE PARENTING AS A PROTECTIVE FACTOR FOR CHILDREN'S MENTAL HEALTH

There is a large body of evidence indicating the pivotal role of positive parenting on improving children's health outcomes [78, 79]. The term positive parenting practises refers to parental warmth, positive affection, being responsive to the child and not to infringe on the child's autonomy [55, 78]. Positive parenting practise and parents' engagement in their child's academic and future plans were associated with decreased depression, high self-confidence and good academic achievement in children [80]. Positive parent-child relationships were also associated with improvements in children's mental health, academic achievement and their future position in society [81-83].

2.3.1 Parenting support programmes

The idea of supporting parents to promote the development of children and increasing children's protective factors for mental health has been underscored in the Swedish government's National Strategy for Parenting Support [84]. The term parenting support is defined as "an activity that gives parents knowledge of children's health, emotional and cognitive as well as social development and strengthens parents' social networks" [9, p.4]. A wide range of interventions are offered to parents with children aged from 0-18 years, with a focus on prevention, promotion, or both [84].

There is a substantial body of theoretical and empirical evidence showing that parenting support programmes promote family functioning, positive parenting practises, parent-child relationships, decrease children's emotional and behavioural problems [81-83, 85-89], improve parents' mental health [90, 91] and sense of competence in parenting [92]. Several standardised parenting programmes have been developed over the past few decades, which are either derived from social learning theory or attachment theory. The aim for all parenting programmes is to promote positive parenting practises and strengthen parent-child relationships, leading to positive outcomes for children's mental health [87-89]. Parenting programmes are delivered in individual or group interventions, or a mixture of both. The social learning theory parenting programmes such as 'Parent Management Training - Oregon Model', 'Triple P', 'ABC', 'All Children in Focus' and 'Incredible Years' focus on children's behaviour by encouraging positive behaviour in children, showing disapproval of inappropriate behaviour, setting boundaries and showing affection as well as strengthening the parent-child relationship [82, 93-95]. The Connect parenting programme, based on attachment theory, focuses on strengthening the parent-child relationship and attachment by enhancing and stimulating parents to develop sensitivity towards their child's behaviour, reflecting on their emotional responses, and to build a partnership with their child [96-98].

Group-based parenting programmes share common characteristics in terms of delivery format and content, although they use different approaches. Some are aimed at targeting children in risk groups (selected programmes), i.e. children with conduct problems, children showing anti-social behaviour, and families in the highest risk groups [86, 93, 95, 97, 99]. In contrast, some programmes are aimed at improving the mental health of the entire population (universal programmes). Finally, some parenting support programmes use mixed approaches, a combination of selected and universal programmes, such as Triple P [99] and Connect, which has also been used as a universal parent programme in Sweden [100]. The similarities between these parenting programmes are that they are delivered to a small group of parents on a weekly basis for 4-12 weeks, with 1-2 group leaders, that they use reflections, exercises and role plays and, except for the Connect programme, they use homework [87].

2.3.2 Parenting support programmes for immigrant parents

Even though parenting support programmes are well-established and some of the parenting support programmes (e.g., Parent Management Training - Oregon Model, Triple P' and Incredible Years) have been delivered to immigrant parents in different context [101-103], studies report the difficulties to engage, recruit and retain immigrant parents [104-108]. Some of the reasons underlying immigrant parents' underrepresentation in parenting programmes include lack of information about the existing services, lack of trust towards professionals, practical difficulties such as time limitations, lack of transportation [104, 109] and language barriers [110, 111]. Low socio-economic status, experiences of discrimination [109, 112] and lack of cultural sensitivity in the parenting programmes are other factors that contribute to difficulties in engaging and retaining immigrant parents [104]. There is a scarcity of evidence on the effects of parenting support programmes on immigrant parents mental health (and the mental health of their children) and their sense of competence in parenting [104, 113]. Some studies have reported that parenting support programmes for immigrant and ethnic minority parents decreased child behavioural problems [114-116] and increased parental skills, parental behaviour and sense of competence in parenting [116, 117]. Other studies, however, showed no improvement for parents' mental health [91, 115, 118] and limited [91] or no effects [103] on children's behavioural problems. Recently, research has highlighted the importance of exploring different strategies to recruit and retain immigrants and ethnic minorities, as well as in making parenting programmes more attractive [81, 101, 107, 113, 119].

2.4 CONCEPTUAL FRAMEWORK

The challenges of being a parent are universal and can be experienced by all parents, but being an immigrant parent involves, in addition, a new culture, a changed context and social transformation, which may create greater challenges in parenting.

Parenting is often shaped by the individual's internal and external resources (i.e. beliefs, attitudes, values, family structure, social network, social support and well-being). Culture is considered to influence parenting through parents' belief and behaviour as well as the context where they raise their children [120, 121]. However, this does not mean that culture is static; rather, it is dynamic and changes constantly through social interaction in which individuals reconstruct and renegotiate in the context where they are living [122]. Thus, the most essential determinants of parenting are contextual factors [50, 53, 54, 123]. Studies argue that a wide range of contextual factors should be considered to understand and support immigrant parents in the new host country (e.g., access to social and financial support and social inclusion) [2, 48, 124].

This thesis has adopted Ochocka et al. [2] framework for understanding immigrant parentings' acculturation, not only to frame and understand the process of parenting acculturation among immigrant parents but also to develop and implement culturally tailored parenting support programmes (Figure 1).

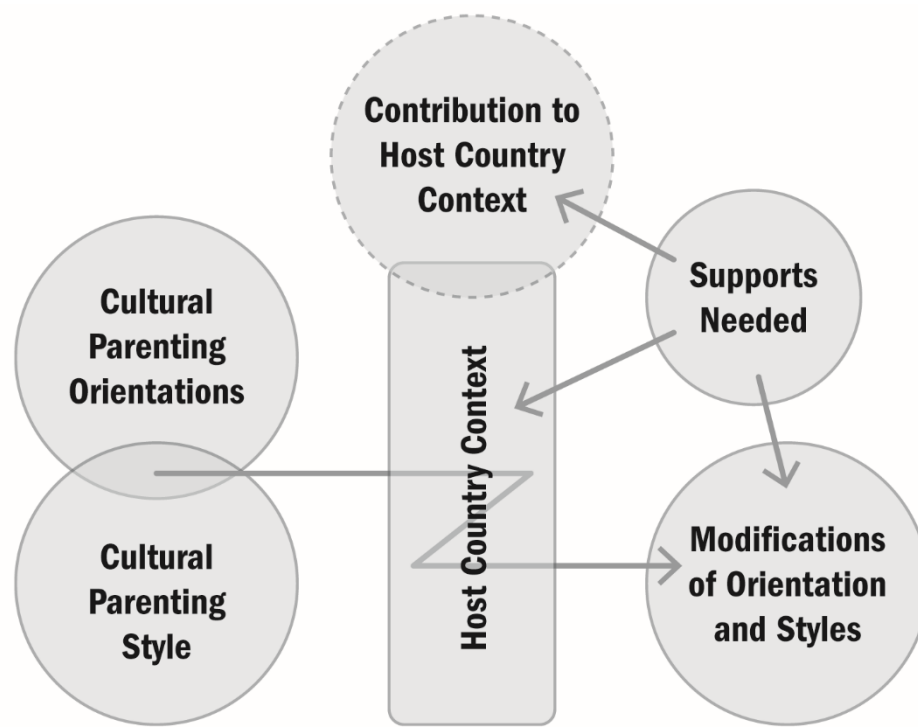


Figure 1. Ochocka & Janzen, (2008). Orienting Framework for Understanding Immigrant Parenting

Ochocka et al. [2] framework starts with *cultural parenting orientations*, which include parents' cultural beliefs, attitudes and values on how a “good” parent should be, but also how the child should behave according to the parents' beliefs and values. Related to the ecological contextual view, parents are influenced by the socio-historical and cultural conditions as well as their individual life events and health [120]. In cultural parenting orientations, parents have expectations and hopes for their children that they want to perpetuate, such as family relationships, religion and culture [2]. The second component in the framework is *parenting styles*, which describe parents' child-rearing practises and how parent and child socialise and interact with each other in relation to parents' cultural parenting orientations. As with the cultural parenting orientations, the parenting styles are influenced by the parents' socio-historical and cultural background, as well as their life events, which are formed in the context and culture of origin [120].

Migration brings changes in both culture and context, which might have an impact on parenting orientations and styles – the third component in the framework, *host country context*. Parents start with the host country's context to compare their way of parenting with what the host country considers the “parenting way”. They might experience that their parenting practices are supported or challenged in the transition and acculturation process. During this process of acculturation in the new country and to a new way of parenting, parents start to make *modifications in their parenting*, consciously or unconsciously. The modification starts when parents interact with the surrounding systems and environment, which then contribute to the modification. The acculturation and transition to the new country might not occur at the same time for parents and children, as children may adapt to

the new country more rapidly than their parents. Consequently, they might question or categorically reject parents' orientations and parenting styles that they think contradict the new context in which they are living [40]. This also contributes to parents more consciously modifying their way of parenting. The fifth component is *parenting contributions*, which includes the interaction between parents and the surrounding environment. This component contributes to the bidirectional process of interaction and influence. Parents adjust to the new context and society as well as influence and contribute to the new context. However, for parents to make the transition and acculturation process, Ochocka et al. [2], in their final component, suggest the need for *parenting support* for immigrant parents in three areas: 1) support in the settlement and acculturation process to the host country; 2) support in the process of modifying their parenting orientations and styles; and 3) support in the facilitation of the integration process between newcomers and the native population. The focus of this thesis is the first two support areas, supporting with the acculturation process and modifying parenting orientations and styles, both of which are related to Berry's acculturation process [33].

3 RATIONALE

This thesis originated in the Swedish government's efforts to promote children and young people's physical and (particularly) mental health. A host of studies have shown that evidence-based parenting support programmes provide substantial effects on parents' ability to promote positive parenting practises. Moreover, they strengthen the parent-child relationship and parents' sense of competence, which improves children and parents' mental health. However, several studies have pointed out challenges in reaching and retaining immigrant parents in universal parenting support. During the past decade, the Somali population in Sweden has increased and is one of the largest groups among African immigrants in Sweden. It has been reported from different municipalities in Sweden the difficulties to access parental support to Somali-born parents and other immigrant parents. Several official reports from Sweden have highlighted the importance encouraging immigrant parents' participation in parenting support programmes to reduce the existing inequity in health [9, 84, 125]. From a public health perspective, it is crucial to develop and evaluate interventions that are tailored to the needs of immigrant families. Moreover, immigrant families encounter different complexities and challenges in the host country and need support that facilitates this transition. Lack of cultural sensitivity in parenting support programmes has been related to low participation and high dropout rates of immigrant parents [104]

In summary, there is a knowledge gap on Somali-born parents' need of support in their parenting and how to engage them in parenting support programmes. Furthermore, there is scarcity of studies on immigrants from Somalia on the effectiveness of parenting support programmes on children and parents. Therefore, more studies are needed on the effectiveness of parenting support programmes adapted to immigrant parents.

To respond to the need of parenting support programmes to Somali parents, it is important to provide a culturally tailored parenting support programme to facilitate integration into the host country while still maintaining a sense of their cultural identity [126]. Moreover, parenting support programmes can strengthen parents' sense of competence in parenting and the parent-child relationship, which is a protective factor for improving children's mental health. In this thesis, Somali-born parents were offered a culturally tailored parenting support programme and the children's mental health was assessed through parents' self-report.

4 AIM

The overall aim of this thesis was to develop and evaluate the effectiveness of a culturally tailored parenting support programme on the mental health of Somali-born parents and their children. A further aim was to explore the parents' experience of such a support programme on their parenting practises.

The specific aims were:

- To explore Somali-born refugees' experiences and challenges of being parents in Sweden and the support they need in their parenting role (Paper I).
- To evaluate a culturally tailored parenting support programme for Somali-born parents and assess its effectiveness in improving children's emotional and behavioural problems (Paper II).
- To evaluate the effectiveness of a culturally tailored parenting support programme on the mental health and sense of competence in the parenting of Somali-born parents. A further aim was to examine whether the intervention affected the mental health of parents, owing to their new sense of competence (Paper III).
- To describe Somali parents' experiences of participating in a culturally tailored parenting support programme and how the program affected their parenting. Another aim was to determine which parts of the Ladnaan intervention were the most influential on their parenting practises (Paper IV).

The logic underlying the studies is presented in Figure 2.

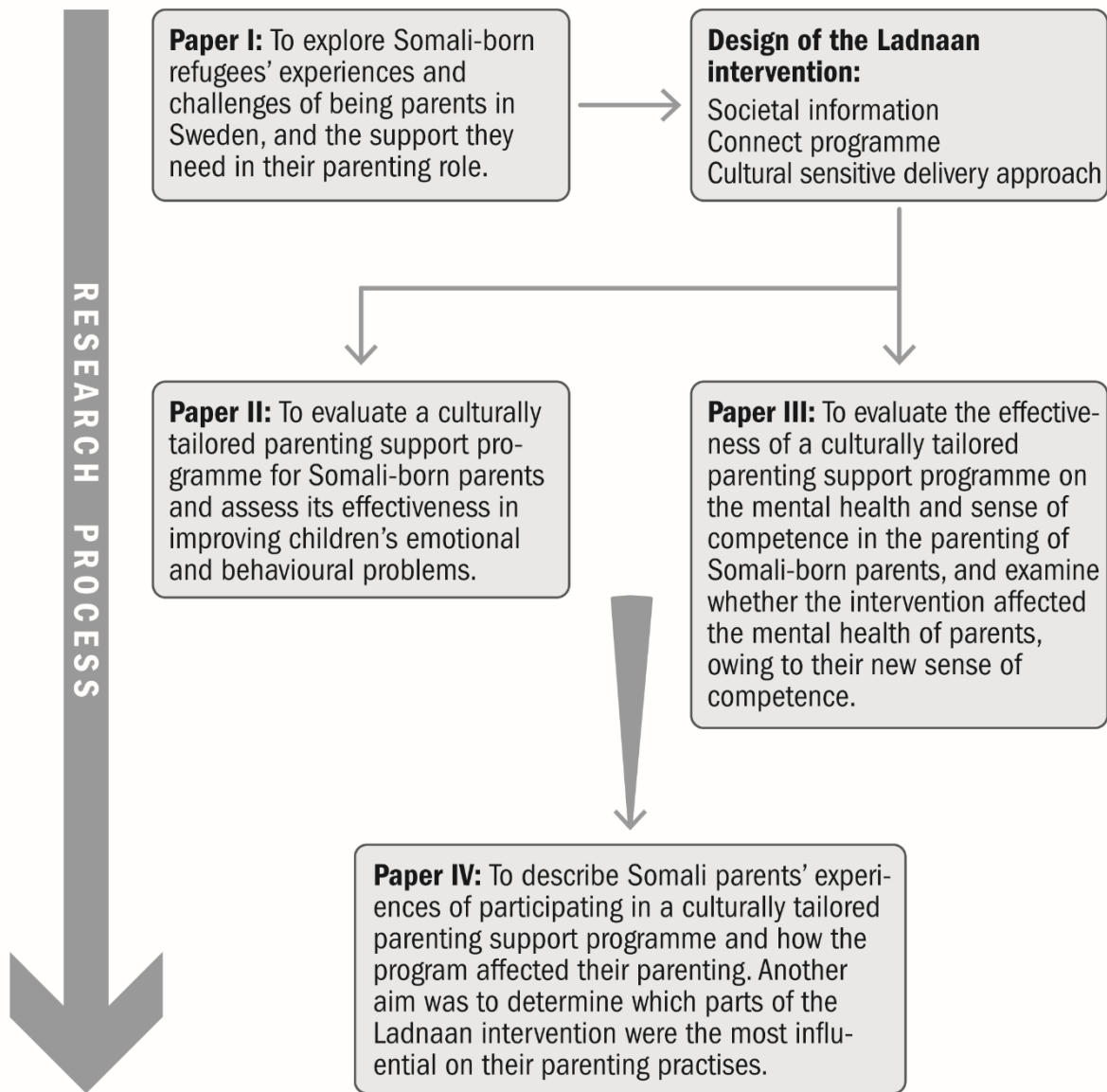


Figure 2. The logic underlying the research process

5 METHODS

Caalinow, Ta' iyo Wow, bal tixraac halkaan maro!

Caalin, listen, check where I go from A to Z. (Somali Poem by Mohamed Hashi Dhamac).

5.1 STUDY DESIGNS AND METHODS

To develop a culturally tailored parenting support programme, the thesis started with an explorative qualitative study (study I, paper I) which aimed to explore Somali-born parents' need for parenting support. These findings were subsequently used to tailor the parenting support programme (study II). With the aim to evaluate the culturally tailored parenting support programme on children's and parents' mental health, a randomised controlled trial (RCT) was conducted (study II, paper II and III). Furthermore, the effectiveness of the culturally tailored parenting support programme on the sense of competence in parenting was evaluated (study II, paper III). The RCT study followed the CONSORT (Consolidated Standards of reporting trials) guidelines for non-pharmacological treatments [127]. To further understand the impact of a culturally tailored parenting support programme on participants' parenting, a qualitative study was conducted with parents in the intervention group, after follow-up data were collected (study III, paper IV). The methodological description of the studies is summarised in Table 1.

Table 1: Overview of study design, methods, participants and analysis

	Study I	Study II		Study III
	Paper I	Paper II	Paper III	Paper IV
Design	Qualitative	Randomised controlled trial	Randomised controlled trial	Qualitative
Participants	Somali parents living in a municipality in central Sweden (n=23).	Somali parents with children aged 11-16 years, and with self-perceived stress regarding parenting (n=120).	Somali parents with children aged 11-16 years, and with self-perceived stress regarding parenting (n=120).	Parents in the intervention group (n=54).
Data collection	Focus group discussions collected before intervention.	Parent report of Child Behaviour Checklist 6-18 (CBCL 6-18). Data collected at baseline and 2 months after the intervention.	General Health Questionnaire 12 (GHQ-12) to measure parent's mental health. Parenting sense of competence (PSOC) to measure efficacy and satisfaction in parenting.	Individual semi-structured interviews collected 2 months after the intervention.
Data analysis	Inductive qualitative content analysis.	Descriptive statistics. ANCOVA, clinical significance and Mediator analysis. (according to intention-to-treat).	Descriptive statistics. ANCOVA, clinical significance and Mediator analysis. (according to intention-to-treat).	Inductive and deductive qualitative content analysis.

5.2 SETTINGS

These studies were undertaken in a mid-sized municipality in Sweden with a population of 51 000. By the end of 2016, 17% of the population living in the city were foreign-born [128]. The Somali group was one of the largest immigrant groups in the municipality. In 2009, the Swedish government had developed a national strategy to promote children and young people's health through parenting support in which municipalities, county councils and universities were encouraged to develop a universal parental support aimed to reach parents with children from 0-18 years [84]. The Social services in the municipality had experienced difficulties to reach immigrant parents and the municipality was positive to find ways to engage hard-to-reach groups in the parental support intervention.

5.3 STUDY I

5.3.1 Participants and recruitment

This study formed the basis for developing a culturally tailored parenting support programme. The study also involved identifying key individuals and gaining access to the Somali community. According to Ochocka et al. [129], gaining access to the community is vital when an intervention is conducted at a community level and particularly in difficult to reach groups.

The participants were selected with the explicit aim of including participants who had lived with their children for a minimum of one year and are now a resident in the municipality. Regarding an information meeting for the study held in one of the Somali association's venues, prospective participants left their contact details with the researcher. Sixteen participants gave their consent to participate (12 women and four men). Additional recruitment was conducted through snowballing (n=10). The participants could choose if they wanted to participate in a mixed group of focus group discussions (FGDs) consisting of both mothers and fathers or a non-mixed group. Of the 26 participants invited to the FGD, three participants, two mothers and one father, were unable to join the FGDs because of illness or other personal reasons. Totally, 23 mothers and fathers participated in four FGDs.

5.3.2 Data collection

To explore Somali parents' own experiences and perceptions of parental challenges and need for support in study (I), data were collected through FGDs. FGDs are a preferred method of data collection when the researcher wishes to obtain perspectives and knowledge on issues that are experienced within the social environment and context [130]. In this study, the aim was to gather knowledge on Somali parents' experiences of migration and on being parents in a new country compared with their home country and their need for support. Four FGDs were conducted, two in mixed gender groups (both mothers and fathers), one with mothers only and one with fathers only. Reasons for both mixed and non-mixed groups were to obtain different perspectives and ideas in relation to whether parents are in the mixed group or the

non-mixed group, and to determine whether parents preferred to be in a mixed or non-mixed group in the intervention.

All the FGDs were conducted in Somali. The first author (FO) moderated three of the four FGDs and was observed by a female Somali-speaking facilitator. The FGD with fathers was moderated and observed by male facilitators. Before and after each FGD, the moderator and the observer discussed their roles in the FGDs. The moderator's role was to present the subject matter and ensure that the participants adhered to the topic. The observer's role was to take notes during the discussions relating to the group interaction. After each FGD, the moderator and observer reviewed the material together. An interview guide was used for the FGDs, and all FGDs started with a broad discussion question on how parents experienced being parents in Sweden as compared with Somalia. The moderator acted as a discussion leader and guided the participants through the discussion; on occasion, when some of the participants dominated the discussion, the moderator encouraged the more passive participants to get involved in the discussion. The moderator also occasionally interjected to ask probing questions. The group which discussed most intensively was one of the mixed groups, where parents passionately discussed gender roles back home and in the new country.

All FGDs were conducted in one of the Somali association's venues, The FGDs, lasting from 1-1.5 hours, were audio-tape recorded. The first author transcribed two FGDs and two FGDs were transcribed by a facilitator. The transcribed FGDs were then translated from Somali into English (total 79 pages) by a professional translator and cross checked by the first author and an independent translator.

5.3.3 Data analysis

Qualitative content analysis was used to analyse the FGDs. All data were analysed manually. The analysis started with an inductive approach to achieve sense content understanding. This method is suitable when the researcher is searching for understanding on how a phenomenon is perceived and experienced by participants [131]. The first author started with the initial analysis by reading all transcribed data several times and taking notes. The words, phrases or paragraphs that captured the participants' experiences were then highlighted and coded into initial codes. This process continued until all the data were coded into an initial code scheme. All codes were then sorted into groups of codes according to their similarities, and constituted subcategories. In this progress, both the first and last author discussed codes and subcategories. The same process of relating subcategories to each other was performed and the level of abstraction of categories was identified. The codes and subcategories that emerged from the four FGDs did not differ with respect to mixed or non-mixed discussion groups. The process of analysis was not linear but moved back and forth, and discussed between all co-authors until all agreed with the final categories and subcategories.

5.4 STUDY II

5.4.1 Recruitment and samples

This RCT study aimed to evaluate the effectiveness of a culturally tailored parenting support programme on the mental health of parents and children [132]. The inclusion criteria were Somali-born parents with children aged 11-16 years and parents with self-perceived stress relating to their parenting. The exclusion criteria were parents who were participating in another parenting programme during the present study and parents with severe mental illness (e.g. schizophrenia, psychosis, bipolar disorder). The choice to include parents with children aged 11-16 years was based on the findings from Study I and discussion carried out with Somali-born parents and key persons living in the municipality. In study I, parents expressed a need for a parenting support programme for their preteens and teens in order to strengthen parent-child relationships.

To engage and recruit parents to the parenting programme, information meetings were held in the neighbourhood where much of the Somali community reside. Participants were given information about the parenting programme and the RCT study procedure. They were assured that if they were allocated to the waiting list and needed support for their parenting, it would be offered after follow-up data were collected. Parents were also informed that after completion of the parenting support programme they would receive a diploma. This was a strategy to engage parents in the intervention. Parents who were willing to participate in the study received contact details from the researcher for further contact. An information brochure was developed to disseminate and recruit for the parenting programme. The information brochure was available in Somali and Swedish and distributed through different facilities in the city and during the meetings. The participants were recruited through Somali associations (during the period of the studies, four Somali associations were active in the community), the Social Services (most from the reception where information was given), language schools (Swedish for non-native speakers), other organisations, Family Centres (meeting place for families in a neighbourhood), and through key individuals (individuals who were active in the community) (see Table 2 for the number of participants recruited from each place).

Table 2: Number of recruited participants and place of recruitment

	Participants
	n
Recruitment via Somali associations	53
Recruitment via key individuals	29
Recruitment via social services	7
Recruitment via school and other organisations	26
Recruitment via family center	1
Recruitment via snowballing (through parents who participated)	4
Total	120

The sample size was calculated based on reduced emotional and behavioural problems in the children with a medium effect size (Cohen's $d=0.5$) with a power of 80% and a significance level of $p<0.05$. The sample calculation indicated 128 children ($n=64$ children in the intervention group and $n=64$ in a wait-list control group) would confer conclusive results.

In total, 149 parents were assessed for eligibility according to the inclusion criteria. Of these 149, 6 did not meet the inclusion criteria, 17 declined participation and 6 could not participate because of illness or time constraints. In total, 120 parents were randomly assigned to either the intervention group ($n=60$) or a wait-list control ($n=60$). Of these 120 parents, 109 were successfully followed up (57 in the intervention group and 52 in the control group).

5.4.1.1 Randomisation procedure

A computer sequence generator was used to generate sequence numbers in blocks of 10 to obtain an equal distribution, allocating participants to either the intervention or control group (Random Allocation Software) [133]. One of the research group members noted the group's affiliation (intervention or control group) and study number on a piece of paper and placed it in an opaque sealed envelope. Each family had a personal identification number that appeared on the questionnaire. The allocation content of the envelope was not known to the researchers, research assistants or participants at the time the study was being conducted.

Participants who showed an interest in participation were screened for their eligibility following a brief screening protocol. Written informed consent was obtained from each parent at the time of the baseline assessment. Randomisation was carried out after the baseline data were collected. After each participant had completed the questionnaire, the participant chose one opaque sealed envelope and was informed whether he or she was allocated to the intervention or control group. Participants were randomised either to an intervention group or a wait-list control group. When both parents participated in the

intervention, only data from the parent who was screened for the study was used. The control group did not receive any form of intervention but simply told that they would receive the intervention after follow-up data had been collected from both groups. For the parents in the intervention group, follow-up data were collected two months after the intervention.

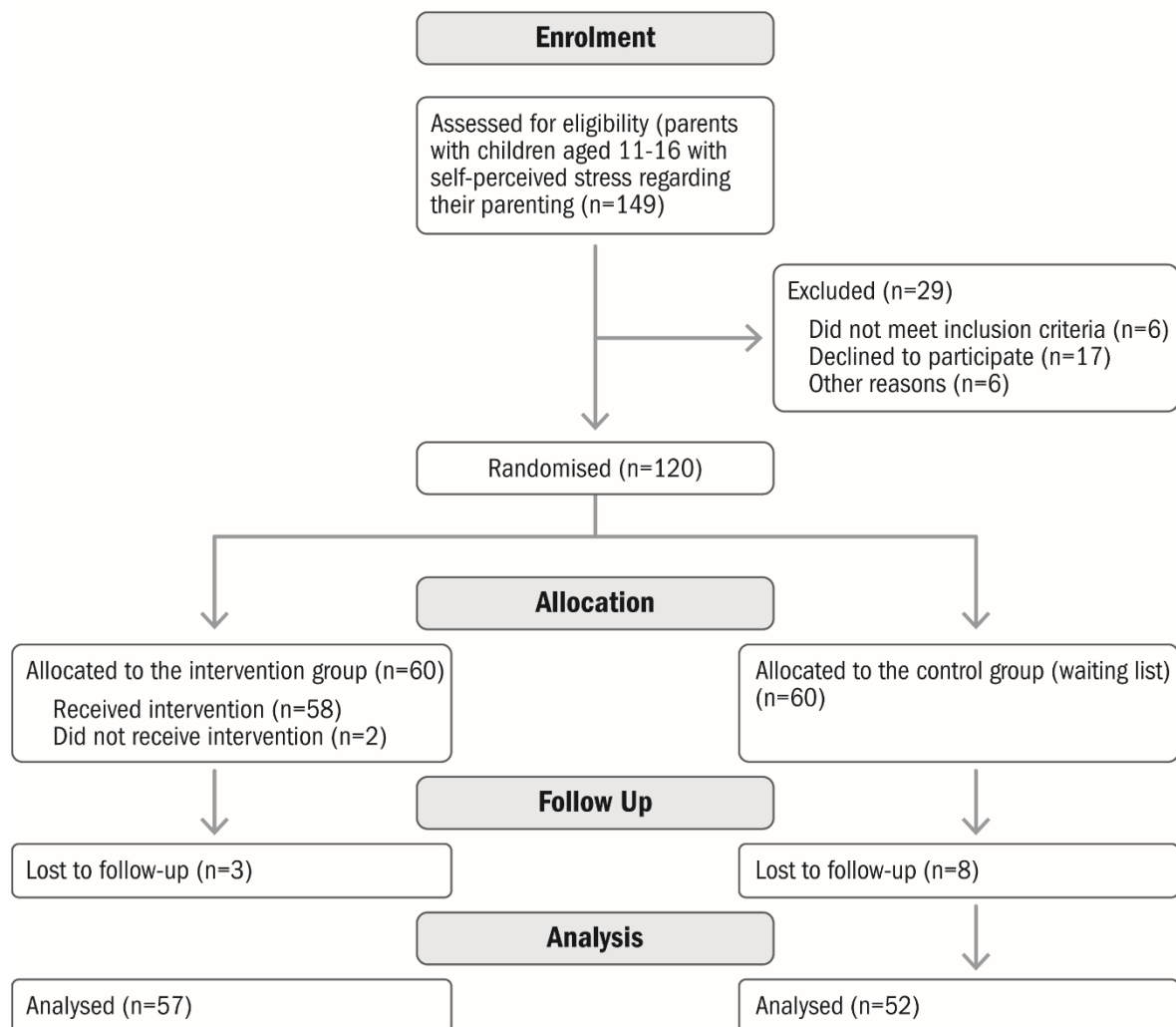


Figure 3. Participant flowchart (study II)

5.4.2 The intervention

Based on the findings from study I, the Ladnaan intervention was developed. Ladnaan is a Somali word meaning a sense of health and well-being. The Ladnaan intervention consisted of three components: societal information, the Connect parenting programme [97], and a cultural sensitivity component, in which the intervention was delivered in the participants' native language by group leaders of similar background and experience, and modifying the examples and role plays in Connect program.

The societal information component constituted 2 of the 12 sessions of the Ladnaan intervention. The content of the societal information was based on the findings from study I, illustrating Somali parents' need of support related to social expectations and obligations as parents in the host country, particularly information related to how child welfare works, parenting styles, and the rights of children and parents. The content was designed together with the research group, professionals from Family and Child Welfare Service in the municipality, and key persons from Somali Associations. This group met several times to discuss the contents related to the findings from study I. The societal information constituted three topics that emerged as being essential for the Somali parents (Study I): Child Welfare Services, parenting styles and the United Nation's Convention on the Rights of the Child (see Table 3). The first topic, *Child Welfare Services*, provided parents with an overall view of the Swedish Child Welfare Services, both the prevention support for families and the assessment of child abuse and neglect. Parents were introduced to the various laws concerning children's placement out of home care. The second topic, *parenting styles*, introduces parents to the different parenting styles and their advantages and disadvantages for children's health and development according to Baumrind's parenting styles [10]. The third topic, *Convention on the Rights of the Child* (CRC), teaches parents the international human rights of children and the promotion of a children's agency. The topics of Child Welfare Services and the CRC were delivered by group leaders of Somali background, and the topic of parenting styles was delivered by a Swedish-speaking professional from the Family and Child Welfare Services and interpreted by one of the group leaders.

The Connect programme is an evidence-based parenting programme that was initially developed for families of adolescents with mental health problems, conduct disorders, substance abuse, and depression [96, 97]. Connect is based on attachment theory and aims to promote children's mental health and strengthen the parent-child attachment relationship [97]. The Connect programme was chosen based on the findings in study I, in which Somali-born parents stressed a need to strengthen their relationships with their children. Moreover, an extensive literature review was conducted by the first author on different parenting programmes. Although most of the parenting support programmes aim to strengthen the parent-child relationship, the Connect parenting programme is the only one that does not focus on children's behaviour (i.e. parents are not taught to regulate the child's behaviour by praising or ignoring) [87]. The primary aim of the programme is to stimulate and increase parents' reflections on their child's behaviour and needs for secure relationships, and ultimately, to develop a dyadic relationship between parent and child.

Connect is a 10-session standardised programme based on nine principles (see Table 3). In each session, parents were introduced to one attachment principle that teaches skills based on children's transitional development and attachment needs. Each session included role plays, case examples and reflection exercises, which comprehensively illustrated the attachment principle. The role plays, scenarios and examples in the manual were culturally tailored to examples that were recognisable to the participants. Group leaders also used metaphors, Somali proverbs and examples from Hadith (action, words and habits from prophet Mohamed) to make it not only comprehensible but also to emphasise certain content. After each session, parents received handouts that summarised the topic.

The third component of the Ladnaan intervention was the cultural sensitivity delivery approach. In total, nine group leaders (five males and four females) were recruited from the municipality where the study was conducted to ensure the sustainability of the parenting programme even after the study concluded. Group leaders were recruited based on being motivated, their cultural competence, pedagogical skills, and having language proficiency in both Somali and Swedish. The group leaders received four days of Connect training and were supervised throughout the intervention by the Connect constructors. Each session was delivered by two group leaders, lasted 1 hour, and was attended by groups of 12-17 parents.

Table 3. The Ladnaan intervention

Session	Intervention topics	Learning and skills goals for parents
Societal information		
1	Child Welfare Services	<ul style="list-style-type: none"> - Gain greater knowledge and understanding on the work of child welfare services with children and youth. - Be familiar with the various laws in the child welfare services.
1	Parenting styles: authoritarian and democratic parenting	<ul style="list-style-type: none"> - Gain greater awareness of their own parenting style and the role that it plays in the child's behaviour. - Gain more knowledge and understanding of parental responsibility regarding personal, economic and social growth. - Increased understanding of the interaction between children and parents are in constant process and development.
2	Convention on the rights of the child	<ul style="list-style-type: none"> - Gain greater knowledge on the United Nations Convention on the Rights of the Child and how it reflects in their parenting.
Connect programme		
3	Introduction on the Connect parenting programme	<ul style="list-style-type: none"> - Overall information about Connect and attachment theory.
4	All behaviour has a meaning	<ul style="list-style-type: none"> - Parents recognise the meaning of the children's behaviour and develop skills to take a step back.
5	Attachment is for life	<ul style="list-style-type: none"> - Develop skills to recognise the attachment needs of the infant, small children, and teens and how each one of them expresses his or her attachment needs.
6	Conflict is a part of attachment	<ul style="list-style-type: none"> - Acknowledge that conflict is a natural part of the relationship between parents and teens. Conflict helps relationships grow when it expressed and responded to in a constructive way.
7	Autonomous includes connection	<ul style="list-style-type: none"> - Develop skills to recognise that teens need autonomy while they want to be connected with their parents.
8	Empathy – the heartbeat of attachment	<ul style="list-style-type: none"> - Practise and acknowledge empathy, which is about being there for the child without condemning or providing solutions to the problem. Listening to the child.
9	Balance our needs with needs of others	<ul style="list-style-type: none"> - Parents to recognise their attachment needs and look for other sources of support than their children.
10	Growth and change are part of a relationship	<ul style="list-style-type: none"> - Parents to understand and become aware of their past and acknowledge what can promote and hinder the teen's change and growth.
11	Celebrating attachment	<ul style="list-style-type: none"> - Acknowledge that in every relationship there are both joy and pain that should be celebrated.
12	Two steps forward, one step back: staying on course	<ul style="list-style-type: none"> - Understand on how to respond when the relationship is turbulent and how that response can establish a reconciliation and strengthen the relationship.
Culturally sensitive delivery approach		
	<ul style="list-style-type: none"> - Delivering the programme in the participants' native language - Group leaders of similar background and experience - Use of metaphors, Somali proverbs, and examples 	

5.4.3 Data collection

Baseline and follow-up data were collected during May 2014 to March 2015. Data were collected by the first author (collecting $n=48$ at baseline and $n=50$ at follow-up) and three research assistants (together collecting $n=72$ at baseline and $n=59$ at follow-up) who were trained in the recruitment process, taking informed consent and in the use of instruments in the study. A guideline for recruitment and data collection was available, and the first author supervised the research assistants during the data collection phase of the study.

The participants were asked to select one of their children with which they had experienced problems as the target child for this study. Participants chose the time and location for the interviews, and the first author or data collectors supported parents in completing the questionnaires if problems arose. Most of the data collection took place at the parents' homes. All parents who participated at the baseline and follow-up assessments were given 150 SEK in the form of a gift certificate.

5.4.3.1 Primary outcome

The primary outcome was to reduce children's emotional and behavioural problems. The Child Behaviour Checklist 6-18 (CBCL 6-18) was used to measure the emotional and behavioural problems at baseline and follow-up [134]. The CBCL 6-18 consists of 133 items encompassing two sections: 1) competence scales comprising 20 items on activities and social scales and 2) emotional and behavioural problems, which comprises 113 items. The emotional and behavioural problem consist of two broad groupings of symptoms: internalising and externalising; three symptoms of social, thought, and attention problems; and a total problem score. According to the instrument's developer, Achenbach System of Empirically Based Assessment (ASEBA), eight items (alcohol- and sex-related) can be excluded for Muslim respondents [135]. In this study, only five sex-related items (item 59, 60, 73, 96, and 110) were excluded. CBCL 6-18 were answered by parents on the target child's current emotional and behavioural problems and for the past 6 months. Cronbach's alpha coefficients for all the subscales were >0.70 . To construct these variables, the ASEBA manual for CBCL was followed step-by-step [135]. Higher scores in the competence and total competence scale indicate having higher competence. For the internalising, externalising and all nine syndromes, higher scores indicate having more problems. The instrument has been validated cross-culturally to measure emotional and behavioural problems among children [135].

5.4.3.2 Secondary outcome

The secondary outcomes were improved mental health of the parents and sense of competence in parenting. For the secondary outcomes, the General Health Questionnaire (GHQ12) and the Parent Sense of Competence (PSOC) scale were used.

The GHQ-12 [136] is a 12-item version of the original GHQ and measures parents' mental health. The GHQ is a psychometric self-rating questionnaire to measure psychiatric distress

experienced by an individual over the past few weeks. The response options range on a four-point Likert scale from 1 (better than usual) to 4 (much less than usual), with higher scores indicating higher mental health distress. A total score was calculated by summing up the items (the total score can range from 12 to 48). Cronbach's alpha coefficient for the total scale was >0.80 . The GHQ-12 questionnaire has been translated into several languages and cross-culturally tested for validity and reliability [136].

The PSOC scale [137] is a 16-item questionnaire that measures the parents' sense of competence in parenting. The PSOC is divided into two subscales (satisfaction with nine items and efficacy with seven items). The response options range on a six-point Likert scale anchored at 1 = *strongly disagree* and 6 = *strongly agree*. The total score for satisfaction items ranges from a low of 9 to a high of 54; for efficacy, the total score ranges from 7 to 42. The satisfaction items were reverse coded. A higher score in both satisfaction and efficacy subscales indicates a higher parental sense of competence.

5.4.3.3 Independent variables

The questionnaire also included information on the participants' socio-demographics: age, marital status, number of children, education level, number of years in Sweden, employment status, residential area, attendance of cultural and community events, parents' exposure to violence, child's age, gender, and highest educational level.

5.4.3.4 Translation of instruments

Approval for translating and using the CBCL 6-18 and GHQ-12 was obtained from the instrument developers. The instrument was translated into Somali following the five steps of the World Health Organisation's process of translation. The steps were: 1) forward translation, 2) backward translation, 3) expert panel back-translation, 4) pre-testing and interviewing, and 5) final version [138].

In the first step, the first author and a bilingual research assistant (previously worked as an interpreter) translated the instruments independently, both with forward translations (from English to Somali), and compared, discussed, and agreed on a reconciliated version. There were two words in particular that both researcher and bilingual research assistant discussed in the instruments CBCL 6-18 and GHQ-12, namely *concentration* and *depressed*. These words could not be directly translated into Somali. After discussion, we agreed on the words *fikiri karin* (*hard to concentrate*) and *madluun* (*worry*). There were also other words in the CBCL that were difficult to translate directly, but were translated as closely as possible to the original translation.

In the second step, a bilingual staff from Family and Child Welfare Services who have good theoretical knowledge of mental health and dealing with issues relating to children translated the material from Somali to English. In the third step, comparison of the backward version with the original version and then with the Somali version was made to check if the forward translation was accurate. A table containing words and sentences for discussion between the

researcher and bilingual staff was created to detect any misunderstandings, mistranslations or inaccuracies. Comments and suggestions in the table were sent to an external reviewer to check the suggestions and to see if the reviewer could add other suggestions. From this process, a second version of the instruments was produced.

In the fourth step, the instruments (CBCL 6-18, GHQ-12, and PSOC) were pilot-tested on Somali parents (three mothers and two fathers). The pilot test was conducted face-to-face during which time the test persons were asked to think of and highlight words or questions that were difficult to understand. During the interview, the researcher took notes on words and sentences that needed to be further explained and, when needed, asked the test person to propose alternatives. In the fifth and final step of the translation process, the last revision of the instruments was made and proofread. No validity and reliability test was conducted on the translated instruments; however, Cronbach's alpha coefficients for all scales was tested at baseline and follow-up.

5.4.4 Data analysis

All analyses were carried out in SPSS (Statistical Package for Social Science) 23.0. An intention-to-treat (ITT) analysis was performed that included all randomised parents in the groups to which they were allocated, regardless of the number of sessions in which they participated, if data were available for follow-up. Sociodemographic characteristics of the participants were presented as percentage and mean \pm SD. To investigate the difference in relation to session attendance, we dichotomised into high or low attendees based on the distribution of attendance, in which high attendees (HA) was equivalent to attending eight or more sessions and low attendees (LA) attended less than eight sessions. This cut-off was based on the median attendance of the 12 sessions.

To investigate the effectiveness of the intervention, an analysis of covariance (ANCOVA) was performed with the values at follow-up (primary outcome and secondary outcomes) as dependent variables and allocation group and baseline values as independent variables. The results from the ANCOVA models are presented as the estimated group mean difference with corresponding 95% confidence intervals (CIs). Effect size of the intervention was calculated according to Cohen's *d* effect sizes, with $d=0.2$ regarded as a small effect, $d=0.5$ as a medium effect, $d=0.8$ as a large effect, and $d=1.45$ as a very large [139].

Clinical significance was examined to determine whether the intervention led to a clinically meaningful and reliable change. The reliable change index (RCI) recommended by Jacobson et al. [140] was used. Because population norms for CBCL 6-18, GHQ-12, and PSOC were not available for the current study population, the standard error of difference (S_{diff}) based on the pretest scores for the intervention and control groups combined was calculated, if the reliability of the measurement for each measure was 0.8. The clinical significance of change from baseline to the two-month follow-up was then tested by comparing the proportion of parents/children in each group who had deteriorated, remained unchanged, and improved

(using a series of chi-square tests) regarding children's externalising problems, mental health, parenting efficacy, and satisfaction.

Three separate mediation models were conducted for this study. First mediation model was on whether parents' mental health was mediated through the change in efficacy and satisfaction in parenting as a result of the parenting programme. The second model was on whether children's decreased behavioural problems (i.e. externalising problems) were mediated through the parents' change in mental health. The third model was on whether children's decreased behavioural problems (i.e. externalising problems) were mediated through the change in efficacy and satisfaction in parenting.

The mediation analyses were performed using a stepwise approach. Regression analysis was conducted to investigate whether parental change in mental health and decreased behavioural problems in children were predicted by parenting efficacy, parenting satisfaction, or both. Change in parental mental health and change in children's externalising problems were inputted as the dependent variable and group membership (intervention or control group), parental satisfaction, and efficacy as the independent variables. Parental satisfaction emerged as a significant predictor of change in parental mental health and children's externalising problems, and was therefore included in the mediation analysis. Mediator analyses were performed according to a suggestion by Preacher et al. [141]. In the first step of the mediation analysis, we tested whether the intervention predicted the outcome (i.e. decreased parental mental health problems and behavioural problems in children - direct effect, c' path). In the second step, the intervention's effect on the mediator (a path) was examined. In the third step, we assessed whether the mediator was related to the outcome after group assignment was controlled (b path). In the fourth step, the indirect effect of the intervention on outcome and the total effect of the intervention were assessed. Finally, the total effect of the intervention was examined (Figure 4). This similar analysis was done for all three mediation analyses separately. A resample procedure of 10 000 bootstrap samples (bias corrected and accelerated estimates and 95% CIs) was used for all mediation analyses. Non-standardised coefficients are reported. The mediation analyses were performed using SPSS macro developed by Preacher et al.

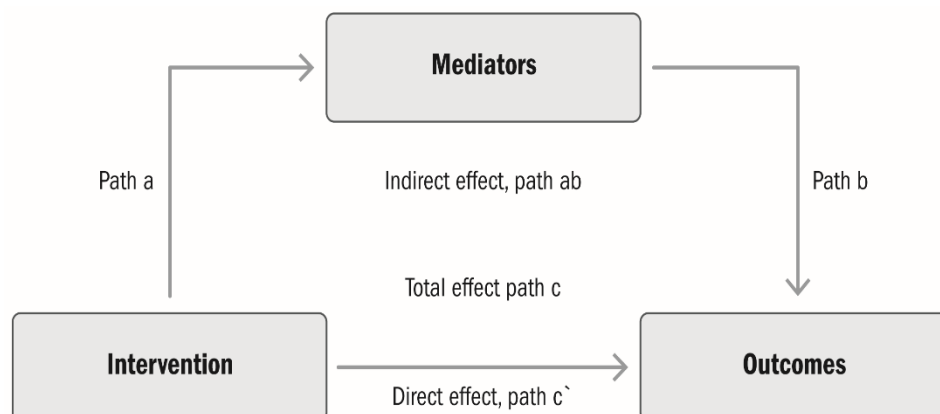


Figure 4. Mediation models. Change in parental mental health and decreased behaviour in children account for the mediators.

5.5 STUDY III

5.5.1 Participants

Parents who had received the parenting support programme were contacted by phone two months after they had completed the parenting programme for follow-up data collection and interviews (N=57). Of these 57 parents, 5 were unable to participate (2 were on holiday leave, 2 did not have the time, and 1 could not be reached by phone despite several attempts). In total, 52 interviews were conducted with 39 mothers, 15 fathers, in which two interviews were with couples.

5.5.2 Data collection

Semi-structured individual interviews were preferred as the data collection method. The study aimed to understand how parents had experienced the culturally tailored parenting support programme, including any identified advantages and disadvantages. All interviews were conducted in Somali and at a location chosen by the participants, typically in the participants' home. Participants who did not give their informed consent at baseline (parents who participated in the couple interviews) were asked to give their informed consent. Participants were also asked permission to tape record the interviews. Three of the participants refused to be tape-recorded, which meant that rigorous notes were taken during those interviews. The first two interviews were conducted with a research assistant trained in interview techniques. Thereafter, 36 interviews were conducted by the first author and 16 by the research assistant. After each interview, the first author discussed the interviews with the research assistant.

All interviews started with the same general questions: "Can you tell me about your experience of participating in the parenting support programme?" and "What was the most valuable part of the parenting programme?" Participants were then asked specific questions relating to the topic of the sessions: For example, "What was your experience of the session conflict as a part of attachment? What did you benefit or miss out from the session?"

Interviews lasted from 15 to 40 minutes. Because of a technical problem with the tape recording device, four interviews had been deleted by mistake. In total, 48 interviews were included in the analysis. All interviews were transcribed in Somali.

5.5.3 Data analysis

Data were analysed in two steps: First, inductive was conducted and then deductive analysis [142]. The analyses were performed using NVivo 11, a computer-assisted qualitative analysis software programme. Inductive analysis was performed to organise the data and achieve a sense of the whole. The first author started with the analysis by reading transcribed data (in Somali) several times to get an overall understanding of participants' narratives. Here, the first author examined the transcribed data in Somali to capture the nuances in the language. Words or paragraphs that captured the participants' experiences were then highlighted and coded into initial codes. This procedure was done with all interviews. After initial codes were extracted from the transcribed data, the codes were then translated into English with all

authors involved in this process. The analysis continued by sorting all codes into group codes according to their similarities, which resulted in several subcategories. The analysis moved back and forth dialectically, and discussions were held with all authors until consensus was reached.

Next, a deductive analysis was done, where a relationship between categories in the deductive and inductive analysis was drawn. A matrix containing the session topic (Table 3) from the societal information and the Connect programme was developed. In the deductive analysis, the transcribed data (in Somali) were read again and placed into the matrix containing session topics. The process continued until all data were placed into the matrix. Thereafter, the contents of the topics were compared with the matrix.

In the final step, the relationships between categories in the inductive analysis and deductive analysis were analysed by comparing the categories from the inductive analysis to the session topics in the deductive analysis. This process was done to capture the way participants talked about the impact of participating in a culturally tailored parenting programme. The use of the triangulation of inductive and deductive analysis increases the validity of the findings as well as deepens understanding the phenomenon in question (i.e. the experiences of the participants) from the participants' perspective [143].

5.6 ETHICAL CONSIDERATIONS

Research on immigrants' mental health, parenting, and child behaviour problems can potentially stigmatising and stereotyping the participants. However, it is important for the researcher to evaluate the risks and benefits for research participants, as well as to discuss ethical considerations. The ethical principles of respect for autonomy, beneficence, non-maleficence, and confidentiality had been considered and applied according to the World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects [144]. Ethical clearance has been obtained from the Swedish Regional Ethical Review Board in Uppsala, Sweden (registration number 2013/296; 2014/048). The RCT study was registered at Clinical Trial (www.clinicaltrials.gov): ID. NCT02114593.

During information meetings, screening and before data collection, all participants were given oral and written information concerning the study. Neutral words were used during information meetings to launch the study. For instance, instead of using the phrase "parental support" in Somali, which could be interpreted to mean that parents are not "good parents" and need support to be "good parents", the word "parent course" was used instead. Each participant was informed personally about the study procedure, of participation being voluntary, and that they could withdraw at any time without having to disclose reasons. They were also informed that their withdrawal would not have any effect on their participation in future parenting programmes or in their contacts with Swedish authorities. Written informed consent was obtained from the participants at the time of the baseline assessment. The RCT study was also designed to collect data from children. However, many parents refused to give

informed consent for their children and therefore the study contained no self-report data on children. Data collection was performed at a location and time chosen by parents, which also gave them opportunity to choose whether they wanted to participate. Participants who declined participation were never asked their reasons.

There are some potential benefits for the participants in this study. The participants in the RCT may benefit from the parenting support programme and improve their relationship with their children compared with not having participated. In addition, the participants in the interviews were given an opportunity to be heard regarding their needs and tell their story of being a parent in Sweden. Similarly, the participants who were interviewed after the intervention had the opportunity to reveal their experiences.

However, there are also some potential risks in this thesis related to the participants' psychological and emotional health. For instance, the participants might have had enormous hope to be less stressed after the parenting programme, and might become more stressed when the strategies they employed for their children do not have the expected effect on their child's behaviour. However, participants were informed that if they needed individual support, they would be offered this through Family and Child Welfare Services.

Another potential risk might be during FGDs and parenting programme sessions in that it is at this time that parents tend to disclose themselves and their children in front of other people from the community. During the FGDs, the participants were informed to respect confidentiality issues in the group. Although the FGD questions related to their experiences, they were informed that they may choose not to disclose their own experiences if they felt uncomfortable doing so. In the intervention sessions, parents were never asked to share their experiences unless they wanted to; instead, the manual contained fictive examples that participants discussed.

A potential risk with the RCT study is that the participants who experienced substantial stress in their parenting and needed urgent support might be allocated to the wait-list control group. However, the participants who were allocated to the wait-list control group were informed that if pressing support was needed, they would be offered individual support by a family therapist through the Family and Child Welfare Services.

The confidentiality of the participants was protected within the research group. All participants were informed that the questionnaire would be coded and data would be processed anonymously and treated in a manner that respected their confidentiality. Moreover, the participants were also informed that no one other than the research group would have access to the data.

6 RESULTS

6.1 CHALLENGES ENCOUNTERED IN THE HOST COUNTRY AND THE SUPPORT NEEDED IN PARENTING (STUDY I)

Kud ka guur oo qanjo u guur

He drove the cattle from plague to glanders (i.e. went from one trouble to another). (Somali proverb)

The results from study (I) were based on 23 participants (15 mothers and 8 fathers). The age range was 22-48 years for the mothers and 26-53 years for the fathers. The length of time participants lived in Sweden ranged from 3-18 years for the mothers and 4-10 years for the fathers. The mothers had lived with their children in Sweden from 1-18 years and the fathers from 2-7 years.

Challenges related to the pre- and post-migration periods were described by the Somali-born parents in accordance with the Somali proverb above. The pre-migration factors and experience of war were adversities that had affected the parents' mental health, but it was the post-migration period that had a greater impact on their lives and in parenting. An overall experience that Somali-born parents held was a process of parenthood in transition that contained challenges adjusting as parents in the new host country, as well as an opportunity to rethink and improve parenting in the host country.

6.1.1 Challenges related to transition as parents in the host country

The challenges of transitioning in the host country, as described by the Somali parents, were insufficient knowledge and not being familiar with the language of the host country. The language difficulties not only prevented them from acculturating in the country and seeking support but also to support their children to adjust to the host country. Parents relied on informal information from other Somali parents who were also quite new to the country and did not have sufficient knowledge, as described by one parent: the blind leading the blind. However, support from the community was important in the transition to the new home country.

When the people are arriving, they need to get the right information, so that they become people that know the culture and have some education on all the requirements, as well to be informed on their rights....., that one (integration programme) is a waste, I have participated and the main problem with that programme is the information is interpreted and in the process the meaning is changed, so it's always important to address the important issues and our problems. The most important thing to understand is that the children are our main resources and to talk about those topics covering the children. (Father in mixed FGD 1).

Coping with a stressful society, isolation and lack of support from the collective family had a marked effect on their well-being and their adjustment to the new home country.

Experiences of racism and discrimination were reported by the parents as being some of the challenges in the new home country when seeking employment, desiring to live in a better neighbourhood, or when interacting with school staff. Somali parents felt alienated and targeted because of their ethnicity. They experienced that the school staff did not treat them or their children equally. The behaviour from the school staff and other staff was crucial regarding to how confident parents felt towards seeking support for their children.

Lack of knowledge of parenting systems in the host country and support from the collective society who supported them with childrearing were challenges in which parents had difficulties in coping. As parents tried to transition to the new host country, they encountered changes in family dynamics (e.g., role changes between spouses and between parents and children). The acculturation gap between parents and children (usually occurring when a parent has greater attachment to the culture of origin and the child to a different culture) affected the behavioural and emotional functioning of both parent and child, often causing serious conflicts. Some of the participants in the study had perceptions about the empowerment of women and children in the new society, which diminished the authority of the husband and parents.

It (parent-child conflict) usually happens after 1–2 years when he (the child) adapts to the system of the country. In the beginning, he is using his culture and you understand each other without problems, but when he goes to school and meets with his mates and well understands the country and they tell him about the country and its culture and system, and the freedom he has, that is the time when it (the conflict) starts. (Mother in FGD mothers).

In addition, lack of support from the extended family put pressure on families, which easily created conflicts within the family. Consequently, children tended to acculturate faster than their parents in the new society, which led to role changes between the parent and the child. Children became their parents' source of information, which resulted in the children exercising more power in the parent-child relationship in the host country. The children's material demands had increased and, because of the power imbalance, they sometimes coerced their parents to give them things they could not afford. The power conflict between parents and children caused confusion in parenting orientation and styles, where parents used either authoritarian (obedience-oriented) or permissive (passive) parenting styles.

6.1.2 An opportunity to rethink and improve parenting

The parent should be having a friendship based on consistency with his children [.....] if you help and support your children what they need, I mean giving them support when it comes to their education and mental development. Back in Somalia I never spent much time with my children, but I am happy to spend time with them now and I see the importance of it as well. (Father in FGD fathers).

Parents desired to adapt their parenting orientation and styles to the new host country. The most crucial support parents emphasised was to understand how to best adjust to the host country as parents. Somali parents requested specific parental support with a focus on societal information (e.g., information on the rights and obligations of parents and children). The parents stressed the importance of understanding the child welfare system in Sweden and their role in supporting families. For many of the Somali parents, understanding the child welfare system can be burdensome and overwhelming, especially for foreign-born parents from Africa who may experience cultural misunderstandings. Fear of the Child Welfare Services disempowered the parent from being the parent their child needed, and contributed to tensions between the parent and the child. Most of the parents in this study were not familiar with the parenting support services that existed in the community, with many believing that such support would lead to the children being taken from their home. Another form of support they emphasised was strengthening the parent-child relationship, particularly with preteens and teens children. Parents underlined that they felt less secure on how to handle the new conflicts with their adolescents in the new context. The acculturation stress encountered in the host country did not make the situation better for either the child or the parent. Sometimes a conflict occurred between the parent and child because of the long separation (i.e. families fled separately from the home country because of the war or for other reasons). Once reunited in the host country, the parent and child had formed different expectations of each other. Parents highlighted support for how to improve their communication with their children as well as on how to improve communication between spouses since they moved from a collective-oriented family to one that is nuclear-oriented.

To implement a culturally sensitive parenting support programme, Somali parents stressed the importance of having facilitators with cultural and context competence. Moreover, they highlighted the benefits of mixed groups, where both parents can exchange their suggestions, give advice, and negotiate their parenting role in the new home country.

6.2 THE EFFECTIVENESS OF THE CULTURALLY TAILORED PARENTING SUPPORT PROGRAMME ON CHILDREN AND PARENTS (STUDY II)

Sida laama looshaha labiyada ka murayoo

Like the ground can't bring grass from nothing, we can't improve by chance. (Somali song by Omar sholi)

6.2.1 Participants

The characteristics of the participants in study II are summarised in Table 4. Almost one third of the participants (n=33) were fathers and most (98%, n=118) were the biological parents of the child. Two parents were the main caretakers of the child. In both groups, the ages of the parents ranged from 30-70 years. Most parents had lived in Sweden from 1-5 years (61%), had less than an upper secondary level of education (58%), and were cohabiting with their partner (54%) in a low socioeconomic residential area. The number of children living at home ranged from 1-13 and the average age of the children was 13 years (SD = 1.6). There were no significant differences between the intervention and control group in socio-demographic background.

Table 4 Characteristics of the study population at baseline (intervention group (IG) n= 60) and control group (CG) n =60)

Variables	IG n (%)	CG n (%)
Participants		
Mothers	43 (72)	37 (62)
Fathers	17 (28)	23 (38)
Participants' age (mean \pm SD)	44 \pm 8	45 \pm 9
Years in Sweden		
1-5 yrs	39 (65)	34 (57)
6-9 yrs	10 (17)	19 (32)
10 yrs or more	11 (18)	7 (12)
Highest educational level		
Less than upper secondary school	37 (62)	32 (54)
Upper secondary school	22 (37)	22 (37)
University	1 (2)	5 (9)
Occupation		
Unemployed	12 (20)	8 (14)
Parental leave	13 (22)	6 (10)
Studying	29 (48)	31 (53)
Employed	5 (8)	11 (19)
Other	1 (2)	3 (5)
Civic status		
Single	21 (35)	18 (30)
Married	39 (65)	41 (70)
Cohabiting with partner	31 (52)	34 (57)
Number of children living at home (mean \pm SD)	5 \pm 2	5 \pm 3
Financial concerns	21 (36)	15 (26)
Child's gender - boys	36 (60)	33 (55)
Child attending special education	23 (38)	18 (31)
Child's age (mean \pm SD)	14 \pm 2	13 \pm 2

SD = standard deviation

6.2.2 Session attendance

Of the 60 parents randomised to the intervention group, two did not attend any sessions because of illness or lack of time. These two parents did not participate in the follow-up. Two thirds of the parents ($n=40$) attended eight or more sessions (high attendees, HAs) and one third ($n=17$) attended less than eight sessions (low attendees, LAs). Analyses showed a difference between HAs and LAs at baseline. More specifically, children in the HA group had more externalising problems and a total problem score than children in the LA group.

6.2.3 Effects of the intervention on children's behaviour problems and parents' mental health

According to the parents' self-reports, we could find significant differences between children in the intervention group and those in the control group. Children in the intervention group had significantly decreased aggressive behaviour (95% CI, 1.06 to 3.07; effect size, $d=0.76$), social problems (95% CI, 0.64 to 1.70; $d=0.83$), attention problems (95% CI, 0.45 to 1.62; $d=0.4$), externalising problems (95% CI, 0.96 to 3.53; $d=0.60$) and in total problems (95% CI, 1.58 to 7.14; $d=0.50$) at the two-month follow-up (Table 5). The effect size of the change in the symptoms was medium to large. There were no significant differences between the intervention and control group on the competence scales and internalising problems.

There were significant differences between parents in the intervention group compared with parents in the control group in the parents' mental health. The parents in the intervention group had significantly improved their mental health at the two-month follow-up (95% CI, 2.01 to 5.18; effect size, $d=0.85$) (Table 5). The magnitude of the treatment effect was large.

Table 5. Analysis of covariance (ANCOVA) on changes in children and parents' outcomes with effect size estimates at the 2-month follow-up

	Intervention group (n=57)	Control group (n=52)	Model-based mean difference (95% Confidence Interval)	P-value	Effect size
	Follow-up, n=57 Mean (SD)	Follow-up (n=52) Mean (SD)	B (95% CI)		Cohens' d
Children outcome CBCL					
Competence scales					
Social	7.43 (2.16)	7.55 (2.08)	0.05 (-0.73; 0.84)	0.90	0.06
Activities	7.78 (1.80)	7.41 (1.81)	-0.36 (-1.18; 0.46)	0.39	0.22
School	4.93 (0.82)	4.82 (0.65)	-0.17 (-0.45; 0.11)	0.24	0.16
Total competence score	20.02 (3.65)	20.06 (2.93)	-0.28 (-1.96; 1.41)	0.74	0.01
Symptoms					
Anxious	1.70 (1.30)	1.56 (1.83)	-0.08 (-0.67; 0.50)	0.78	0.09
Withdrawn	1.65 (1.43)	1.29 (1.21)	-0.31 (-0.80; 0.17)	0.20	0.29
Somatic complaints	0.44 (1.16)	0.52 (0.98)	0.17 (-0.16; 0.51)	0.31	0.09
Rule-breaking behavior	1.07 (1.31)	1.08 (1.12)	0.23 (-0.21; 0.67)	0.31	0.01
Aggressive behavior	1.28 (2.39)	3.27 (3.00)	2.07 (1.06; 3.07)	<0.001	0.76
Social problems	0.72 (1.11)	1.86 (1.77)	1.17 (0.64; 1.70)	<0.001	0.83
Thought problems	0.53 (0.83)	0.38 (0.95)	-0.15 (-0.48; 0.17)	0.36	0.18
Attention problems	0.77 (1.71)	1.58 (1.83)	1.03 (0.45; 1.62)	<0.001	0.54
Other problems	1.44 (1.36)	1.63 (1.73)	0.23 (-0.36; 0.81)	0.45	0.12
Internalising^a	3.79 (2.86)	3.37 (3.10)	-0.18 (-1.21; 0.84)	0.73	0.16
Externalising^b	2.35 (3.41)	4.35 (3.55)	2.24 (0.96; 3.53)	<0.001	0.60
Total problems score^c	9.60 (7.31)	13.17 (8.29)	4.36 (1.58; 7.14)	0.002	0.50
Parent outcome GHQ-12					
GHQ 12	17.68 (4.57)	21.13 (4.16)	3.62 (2.01; 5.18)	<0.001	0.85

^a includes the symptoms of anxiety, withdrawal and somatic complaints

^b includes the symptoms of rule-breaking and aggressive behavior

^c includes the internalizing and externalizing groups of symptoms and the symptoms of social problems, thought problems, attention problems and other problems

A higher score (mean \pm SD) in the competence scales and total competence score indicate higher competence

A lower score (mean \pm SD) in the internalizing, externalizing, total problem score, all nine syndromes and GHQ indicates reduced problems

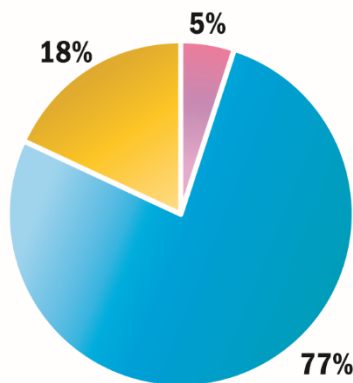
Cohen's d estimates the effect size of parent and child outcome at the 2-month follow-up (small effect d=0.2, medium effect d=0.5, large effect d=0.8, very large effect d=1.45)

CBCL = Child Behaviour Checklist; CI = confidence interval; GHQ = General Health Questionnaire

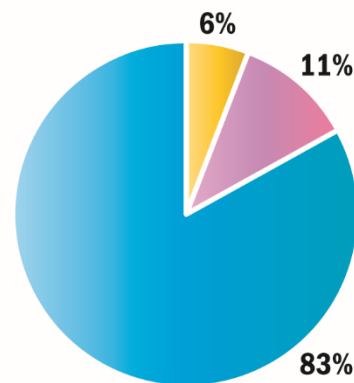
6.2.4 Clinical significant change on children's behavioural problems and parents' mental health

Figure 5 depicts the results from the clinical significance analysis for reduced children's behavioural problems. In the intervention group, 18% (n=10) of the children showed reliable improvement (measured by the externalising problems) compared with only 6% (n=3) in the control group.

Children's behavioural problems in the intervention group



Children's behavioural problems in the control group

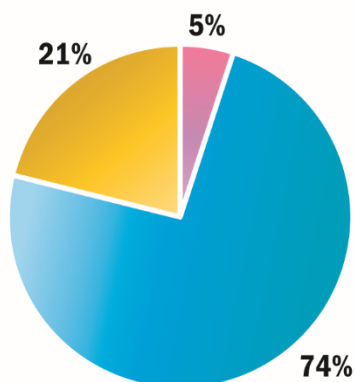


Positive change Negative change No change

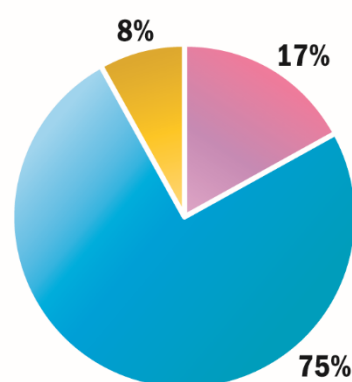
Figure 5. Clinically significant change in children's behavioural problems

The proportion of parents who showed clinically meaningful improvement in their mental health after the intervention was 21% (n=12) in the intervention group compared with 8% (n=4) in the control group (see Figure 6).

Parents' mental health in the intervention group



Parents' mental health in the control group



Positive change Negative change No change

Figure 6. Clinically significant change in parents' mental health.

6.2.5 Effects of the intervention on parents' sense of competence in parenting

There were significant differences between parents in the intervention and the control group on sense of competence in parenting at the two-month follow-up. The parents in the intervention group had significantly increased their parenting efficacy (95% CI, -8.15 to -5.29; effect size, $d=1.81$) and satisfaction (95% CI, -6.27 to -2.69; effect size, $d=0.98$) with a large effect size. Figures 7 and 8 show the positive changes for sense of parenting competence with 29 (51%) and 22 parents (38%) in the intervention group showing reliable improvements in parenting efficacy and satisfaction, respectively, compared to only four (8%) and two (3%) parents in the control group.

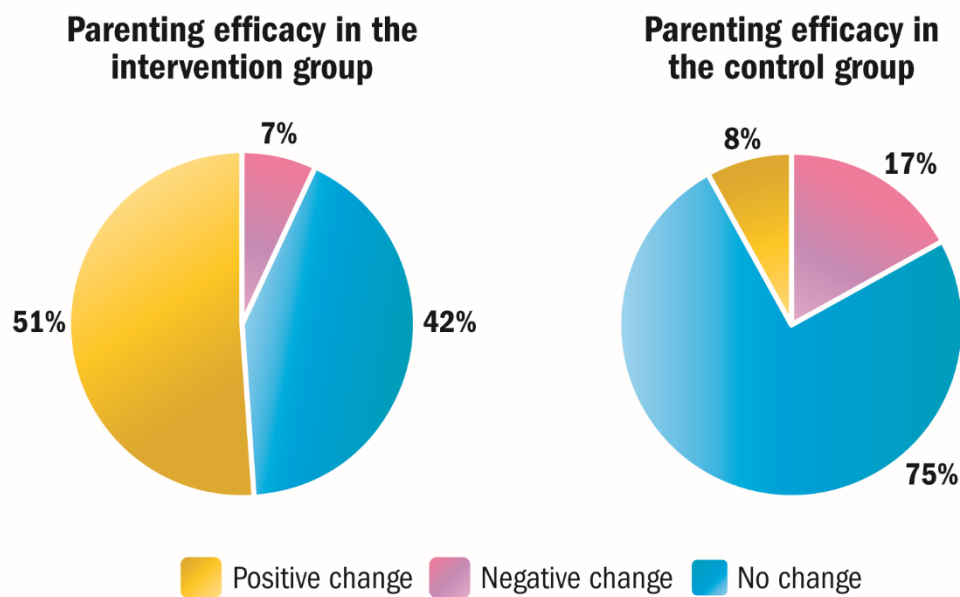


Figure 7. Clinically significant change in parenting efficacy

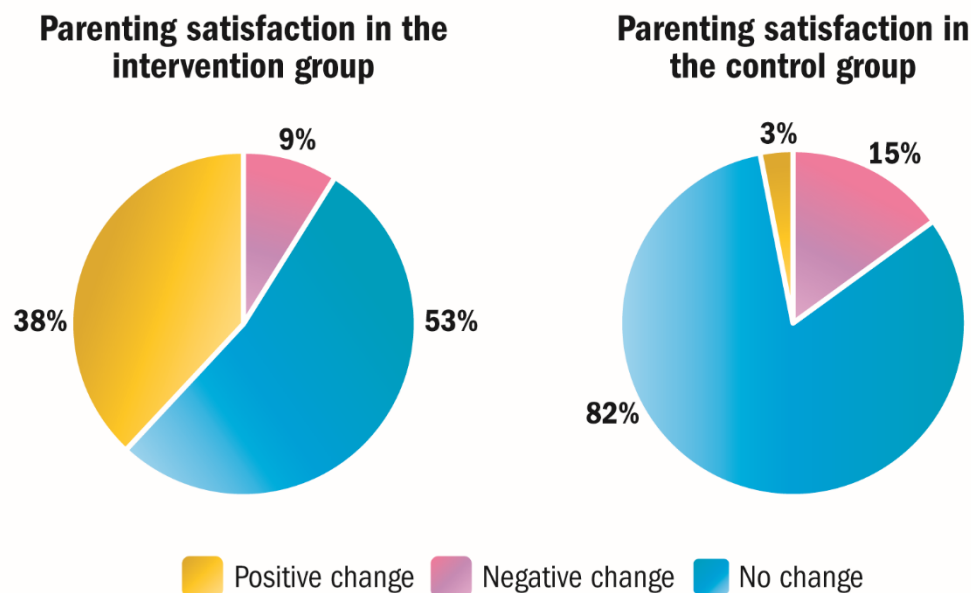


Figure 8. Clinically significant change in parenting satisfaction.

6.2.6 Mediation effect on parents' mental health and children's behavioural problems

Table 6 summarises the three mediation analyses, i.e. whether the change in parental mental health and children's decreased behaviour problems were mediated through parental satisfaction (both parents and children's outcomes) and parents' improved mental health (children's outcome). The mediation analysis pertaining to the parents showed a significant direct relation between the intervention and change in mental health (c path, $\beta = -3.02$, $P = 0.003$). The intervention had an effect on mediator, parental satisfaction (a path, $\beta = 5.34$, $P < 0.001$). In addition, parental satisfaction was associated with changes in parental mental health (b path, $\beta = -0.17$, $P = 0.03$). In the final mediation path model, the indirect effect -- the intervention effect and parental satisfaction -- showed that parental satisfaction partially mediated the change in mental health (ab paths, $\beta = -0.88$, 95% CI -1.84-0.16, $P = 0.047$), with the model explaining 16% of the changes in parents' mental health.

For the mediation analysis on whether children's decreased behavioural problems were due to improved parents' mental health and parental satisfaction, two separate analyses were conducted. The analysis showed a non-significant indirect effect, i.e. the parents' improved mental health and satisfaction did not mediate for decreased externalising problems in children (ab path for parental mental health $\beta = 0.67$, $P = 0.10$ and parental satisfaction $\beta = 0.021$, $P = 0.78$). Parental satisfaction also did not mediate for decreased externalising problems in children (ab path for parental satisfaction $\beta = 0.021$, $P = 0.78$). The total effect of change in externalising problems was significant (c path, $\beta = 3.109$, $P < 0.001$).

Table 6. Mediation model for child and parental outcomes

	Coefficient β	S.E.	P-value	Bootsrap 95% CI
Change in parental mental health via parental satisfaction				
Total effect (c path)	-3.90	0.932	<0.001	
Direct effect (c` path) intervention effect on change in mental health	-3.02	1.001	0.003	
Intervention effect to parental satisfaction (a path)	5.34	1.168	<0.001	
Parental satisfaction to change in mental health (b path)	-0.17	0.076	0.032	
Indirect effect (via parental satisfaction) (ab paths)	-0.88	0.424	0.047	-1.84 to 0.16
Model R ² (P)		0.162	< .001	
Change in children's behavioural problems via parental mental health				
Total effect (c path)	3.11	0.914	<0.001	
Intervention effect to parental mental health (a path)	-3.90	0.932	<0.001	
Parental mental health to decreased behavioural problems (b path)	-0.17	0.094	0.07	
Indirect effect (via parental mental health) (ab paths)	0.67	0.493	0.10	-0.13 to 1.86
Model R ² (P)		0.098	< .001	
Change in children's behavioural problems via parental satisfaction				
Total effect (c path)	3.11	0.914	<0.001	
Direct effect (c` path) intervention effect on decreased behavioural problems	2.10	1.004	0.003	
Intervention effect to parental satisfaction (a path)	5.34	1.168	<0.001	
Parental satisfaction to decreased behavioural problems (b path)	0.02	0.076	0.779	
Indirect effect (via parental satisfaction) (ab paths)	0.11	0.440	0.784	-0.692 to 1.075
Model R ² (P)		0.098	< .001	

Path coefficient, standardised β s = adjusted mean estimate

S.E. = standard error

Direct effect = direct effect of the intervention on change in parental mental health

Indirect effect = total effect - direct effect

Total effect = direct effect + indirect effect

6.3 “A LIGHT HAS BEEN SHED”: PARENTS’ EXPERIENCES OF THE PARENTING SUPPORT PROGRAMME (STUDY III)

Aqoonla`aani waa iftiinla`aan

The absence of knowledge is the absence of light (Somali song).

This study explored the participants’ experience of participating in the culturally tailored parenting support programme, and its influence on their parenting. Individual interviews were conducted with the parents who participated in the intervention group two months after follow-up data had been collected after completion of the intervention.

The overarching category “A light has been shed” describes parents’ understanding on what it means to have knowledge and information related to their rights and children’s rights in the new host country, and strengthening the parent-child relationship, and delivering a parenting programme in a culturally sensitive way.

In the following sections, the Somali parents’ experiences of the culturally tailored parenting support programme (from the inductive analysis) are related and combined with the parts of the programme’s sessions they regarded as most supportive for their parenting in the new country (from the deductive analysis), and the cultural sensitivity in the parenting programme (from the combination of the inductive and deductive analysis).

6.3.1 Enhanced confidence in parenting

The parents underlined that the knowledge gained from the societal information sessions enhanced their confidence and helped them to modify and adjust in parenting in the host country. The sessions also helped the parents to engage in the parenting programme. The most significant session from the societal information sessions was the session on Child Welfare Services’ work with families. The parents described that they obtained information on how, when, and why a child is considered out-of-home care. This knowledge contributed to parents feeling less stressed and worried, felt more confident in their parenting, and felt that they were a “good enough parent”. It was important for parents to obtain information on the process concerning the out-of-home care and that such an action was not due to their ethnic and immigrant background or because they could not afford the child’s material demands (e.g., buying an expensive mobile phone).

Do you know the problem we had? Your child does not listen to you [.....] They don’t do their homework [.....] The challenge was that we could not set any boundaries, because we were afraid of the police and social services [.....] This is the biggest problem that many Somali parents have. We were afraid for our children [.....] but now we know that we can seek support from the social services. (Mother of three children participated 10 sessions).

The knowledge gained from the Child Welfare Services’ work was described as *a light that had been shed*. The initial fears of the social services, school staff and police were greatly

reduced or eliminated when they discussed their rights and responsibilities as parents in the new context. The parents felt that the rights of the children were important topics to discuss both culturally and according to regulations on international children's rights.

6.3.2 Emotionally aware and available for the child through the Connect parenting programme

While the two societal information sessions contributed to confidence in parenting, the sessions in the Connect programme contributed to parents becoming emotionally aware and available for their children. The programme also led to a new parent-child relationship built on trust, openness, and integrity. The parents strongly believed that the six sessions in the Connect parenting programme were particularly valuable in strengthening their parenting: *All behaviours have a meaning, Attachment is for life, Conflict is a part of attachment, Empathy – the heartbeat of attachment, Two steps forward, one step back* and *Autonomous includes connection*. The emotional awareness and availability were manifested through the parents taking a step back, reflecting and relinquishing an authoritarian parenting style for an authoritative parenting style, i.e. a style not as controlling that allows the child to explore more freely and make decisions based on their own reasoning. Parents gained an awareness of their child's behaviour and needs when they stepped back and contemplated about their role as a parent. Such an approach contributed to strategies for dealing with their child's emotional outbreaks instead of entering power struggles with their child. Conflicts were seen as a part of parent-child relationships and all parents agreed that parent-child conflicts are unavoidable, describing it metaphorically as, *"tongue and teeth are close to each other and the teeth might bite the tongue"*. To manage a conflict between the parent and the child, parents reasoned that it was important to give the child space and communicate on equal terms.

Listening to the child without judgement was one of the strategies the parents implemented as a new component of their parenting practise. It was important for the parents to look at every situation from the child's perspective, which was a new way of parenting because of the parenting programme. Because of the parents' emotional awareness and availability, their relationship with their children strengthened and contributed to mutual understanding and respect. An important aspect that the parents highlighted was the transformation the parents made from authoritarian parenting to authoritative parenting. The parents emphasised the importance to provide children their autonomy and still to be close to each other. However, the parents described the importance of balancing and negotiating the independence and interdependence of their relationship: on the one hand, giving children their free choice and on the other, being responsible for their children. The parents highlighted that this balance can be achieved if there is a secure relationship with the child.

The best treasure one can have in this world is their children, so if we don't know how to treat and understand them, then it is difficult, but now everyone knows that.
(Father of four, who participated in nine sessions).

6.3.3 Cultural sensitivity in the parenting programme

The most significant factor the parents mentioned for cultural sensitivity was having a shared language, culture, and migration experience with the group leaders and other parents. The parents also described the importance of the educational skills of the group leaders in delivering the sessions. In addition, the background of the group leaders was deemed important.

It was crucial for parents to receive the sessions in their native language by bi-cultural group leaders who were trained in the Connect training programme. The most important aspect of receiving the content from a group leader in their native language was that they could grasp the understanding of the underlying meaning of the content. Having such group leaders also meant that the parents could get answers to their concerns and questions.

It was good that I received all information in my mother tongue directly without anyone who interprets and half of the information is lost. (Mother of six, participated 12 sessions).

It is good to mix parents from different countries but the difficult part is to have different interpreters; then, no one understands the information in depth because the interpreter will lose some of the meaning and information, and there will not be discussions between parents. So what is the advantage? (Mother of four, participated 12 sessions).

The sessions that were interpreted from Swedish to Somali by the group leaders (Parenting styles) were seen by the parents as being less positive experiences. The group leaders' knowledge, how successful they were in the society, and how respected they were perceived by other community members were characteristics the parents considered important. Furthermore, the educational skills of the group leaders were appreciated, as well as the group leader's creative abilities to make the information more understandable by using metaphors, proverbs, and examples from Hadith (action, words and habits from prophet Mohamed). Each session contained role plays that the parents felt aided in gaining a deeper understanding of the topics in the parenting programme. Role playing also made the sessions more interactive. Meeting other parents, discussing, and reflecting with examples gave them a feeling that they could support each other. The parents stressed that they benefited and learned more from listening to each other.

7 DISCUSSION

*Wadajir beey laba gacmood wax ku qaban karaan – aan is weheshano, aan wadajirno
walaalayaal*

Joined two hands can do things– let us keep company, let us be together (Somali song)

The overall aim of this thesis was to develop and evaluate the effectiveness of a culturally tailored parenting support programme to promote health among Somali-born parents and their children. A further aim was to explore the parents' experiences of such an intervention on their parenting. The overall findings demonstrated that the culturally tailored parenting support programme reduces the parents' many challenges they face when making the transition to the host country. Furthermore, it reduced children's behavioural problems and improved parents' mental health and sense of competence in parenting. The thesis contributes towards a roadmap for how to successfully tailor and deliver a parenting support programme that promotes the mental health of immigrant parents and their children.

7.1 THE EFFECTS OF THE CULTURALLY TAILORED PARENTING PROGRAMME ON CHILDREN'S BEHAVIOURAL PROBLEMS

The culturally tailored parenting support programme led to significant positive effects on children's behavioural problems, aggression, attention, social, externalising behaviour problems and total problems score 2 months after completion of the parenting programme. The findings are supported by several studies [91, 114-116, 145] showing that parenting support programmes that are tailored to immigrant parents decrease children's behavioural problems. However, compared with other studies [91, 114, 115], this study demonstrated a medium to large effect size on children's outcomes. It is also important to stress that less than 1% of the children in our study was in the clinical range (less than 70th percentile) at baseline. Unlike this study, other studies included children who were already in the clinical range or their families reported externalising problems [91, 114-116, 145].

The findings indicate a clinically significant improvement in children's externalising problems. One might argue that only 10 children improved clinically while 44 children remained unchanged, but the reader should be mindful that less than 1% of children were in the clinical range of externalising problems and that the families referred themselves to the parenting programme voluntarily.

The parenting support programme did not reduce the internalising problems in children in the intervention group over the short term. This finding might be explained by the fact that the Connect parenting programme primarily focuses on increasing parents' sensitivity towards their children's emotional needs. Hence, parents generally focus on children's externalising behaviour problems rather than on internalising problems. Furthermore, parents' sensitivity towards their child might take time to take effect [146].

The present study could not discover the underlying mechanism(s) for decreased externalising problems in children: parents' improved mental health and satisfaction in parenting did not mediate the change in children's externalising problems. One explanation could be that it was not tested whether the parents changed their parenting behaviour or parenting practises after the intervention. Normally, parents change their parenting behaviour before children change their behaviour. Studies show that parenting support programmes improve positive parenting practises and skills, which is one of the purposes of such programmes [87, 115, 145, 147]. It also has been reported that parents' positive or negative parenting practises mediate children's externalising and internalising problems [145, 148]. Although we have not statistically tested the underlying mechanism of the change in children's externalising problems, parents who took part in the parenting programme were interviewed 2 months after the intervention. The parents revealed that, when they understood the reasons behind the child's reactions, they changed their parenting behaviour and the child's behaviour towards them was also changed (Study III). Parents stressed that understanding their children's behaviour by stepping back and reflecting before reacting helped them to be more emotionally aware and available. Thus, it may be hypothesised that parenting behaviour and practises had a positive impact on children's externalising problems.

One might argue that the children were invisible in this thesis and one could question how we safeguarded their agency (children's agency refers to children's active participation and ability to act in each situation) and voice according to the Convention on the Rights of the Child (CRC). This is a limitation of the study, which is further discussed in the methodological section. However, the idea of parenting support programmes is to support parents to employ positive parenting skills and strengthen parenting-child relationships, which, in the long run, promotes children's health and development [81-83, 85-89]. The Swedish government's National Strategy for Parenting Support [84] describes that parenting programmes should be based on the principles according to the CRC. Can we still ensure that children's agency has been safeguarded in this thesis? This issue was not evaluated here, but a recent study conducted in Sweden [149] compared the manuals of two parenting programmes (i.e. Connect and All Children in Focus programmes) and related the manual content to the CRC. The finding from their study revealed that the Connect programme had an approach that promoted children's agency, although the manual in Connect did not mention to include the CRC. Thus, it might be hypothesised that Children's agency might have been safeguarded in the Connect programme. Furthermore, the societal information component, there was a session on CRC in which parents discussed some of the articles in the CRC. However, it is difficult to say that if the parents had only received the societal information sessions, would it have promoted children's agency. This is because most of the information that parents used to enhance their confidence (study III) was related to the child welfare services session.

7.2 THE CULTURALLY TAILORED PARENTING PROGRAMME IMPROVED PARENTS' MENTAL HEALTH AND SENSE OF COMPETENCE IN PARENTING

The findings from the RCT study showed that the culturally tailored parenting support programme had a significant effect on parents' mental health with large effect sizes. Study (I) reported that the obstacles Somali parents encountered in the host country led to stress and lower confidence in parenting. This observation has also been reported in other studies. The individual's health is affected by many other factors, and one main factor for parents is the relationship with their children. Thus, when an acculturation gap exists between the parent and the child, an acculturation conflict is unavoidable [43, 44]. Parents in Study (I) reported that their children were the link between them and the wider society, and this created a power imbalance that the children sometimes misused. This, in turn, produced tension in the parent-child relationship and affected parenting practices, i.e. parents become passive in their parenting roles and avoidant of conflict. Several studies have confirmed that when children become the link between the society and the parents or they serve as language brokers, it affects parent-child affection and trust [47, 48]. In addition, the feeling of not providing the child adequate support might affect the mental health of the parents. In Study III, parents in the intervention group felt that they could mentally and emotionally support their children and felt confident in their parenting practices. The societal information component in the Ladnaan intervention helped to reduce parent stress. Parents in Study (I and III) (as well as in previous studies) confirmed that Somali parents see their children as a treasure and the feeling that the authorities might take their child away triggered excessive anxiety and stress. In several studies, parents experienced constraints rather than support from social workers [31, 52-54]. All these results demonstrate that parents need to get information about children's rights, as well as their rights and responsibilities as parents because providing only one-sided (e.g., only children's rights) information may cause anxiety and lead to passive parenting (i.e. the parent shows unwillingness to impose rules and discipline).

A particularly noteworthy finding was that the parents' improved mental health was partially explained by their satisfaction in parenting. This observation might be related to parents' enhanced knowledge of the parenting systems in the host country (Study III). In this study, parents reported that they recognised that they were "good enough" parents, which increased (and rebuilt) their confidence in parenting. Moreover, parents started to understand the reasons underlying their children's behavioural changes and began to see things from the child's perspective. Parent satisfaction with parenting has been shown to have an impact on the parents' mental health, which underlines the importance of supporting immigrant parents with their parenting in the new host country. Such support serves to improve the mental health of parents and children but also serves to strengthen their relationship.

The culturally tailored parenting support programme induced a substantial increase in parents' sense of competence in parenting (i.e. efficacy and satisfaction in parenting). Moreover, clinically meaningful improvements were detected in parents' mental health, efficacy and satisfaction in being a parent. This finding was also confirmed in the qualitative

interview in Study (III). Through the parenting programme, parents became emotionally aware and available for their children. Because the Connect programme does not teach parents any particular strategy towards children's behavioural problems, parents individually identified strategies that worked for their child [149]. Instead, parents were encouraged to take a step back, try to reflect what the child's behaviour represents and then take a step forward and fulfil the child's physical, emotional and intellectual needs. Such an approach may contribute to the empowerment of parents. Parents in this study (III) reported that becoming conscious of their parenting led them to abandon the authoritarian way of parenting and instead support the child's autonomy and self-determination.

7.3 ROADMAP TO CULTURALLY TAILOR PARENTING PROGRAMMES

Study (I) was the starting point for developing and implementing a culturally tailored parenting support programme for Somali-born parents in Sweden. Ochocka et al.'s [2] framework was used as an orientation to understand the process of parenting acculturation among immigrant parents and to develop and implement a culturally tailored parenting support programme. The framework emphasised the cultural factor of parents' parenting orientations and styles. However, there are several challenges that parents (study I) reported that hinder a successful transition to the new host country. One of the main obstacles is contextual factors, such as a lack of knowledge of the host country's culture and lack of information on parenting systems in the host country. They reported a fear of Child Welfare Services, which contributed to a lowered confidence and stress in parenting. This finding is in line with several studies in which parents reported low confidence in parenting and contributed to negative parenting practices, i.e. parents used either authoritarian or passive parenting styles [30, 31, 34, 49, 54]. Challenges in transition and acculturation into the new home country prevented feeling confident in their parenting. Participants (study I) had experienced acculturation factors as stressors to their parenting. Several studies have confirmed similar challenges that immigrant parents encounter in the host country, regardless of their country or culture of origin [38, 49, 50, 52, 53]. These seem to be post- rather than pre-migration challenges [14-16, 27-29] and affect individuals' mental health negatively [16].

The findings from this thesis add an important factor to Ochocka et al.'s framework, which is that contextual factors may have an influence on family interactions. The context of the new home country implies different changes and has an influence on family structure, family values and the interaction between parent and children [41]. In addition, the lack of an extended family to support childrearing was a contextual challenge that Somali parents felt contributed to their feelings of disorientation, loneliness and stress in parenting [30, 31, 34, 38, 39, 49-51, 53, 54].

The current findings demonstrate that parent-child conflicts cannot be reduced to merely a cultural problem. This is because it would lead to ignoring the acculturation stressors and the contextual factors that parents and children face in the host country. Moreover, it would lead to a simple explanation of the specific support immigrant parents need and to increase inequalities. Nevertheless, Ochocka et al.'s framework [2] and Berry's acculturation theory

[32] suggest that the process of adapting to a new country is dynamic and dualistic, in which social context influences the family and the family influences the social context. Even the reason for migration, i.e. voluntary or involuntary migration may influence the process of acculturation and family interaction [41, 42].

Ochocka et al. [2] noted that in the process of acculturation in the host country, parents start to think about their parenting styles and desire to adapt. Somali parents in this study expressed a desire to modify and rethink their parenting practices, which they experienced as being different from the parenting system in the new country. Several studies [2, 81, 107, 113, 119] have outlined the need and importance of tailoring parenting programmes so they are consistent with the immigrant parents' culture and context. Some studies [104, 113, 119, 123, 150] recommend that the parenting programmes should be socially relevant to immigrant parents in which practitioners identify and understand the attitudes and needs of the parents. From the findings of Study I, societal information component were and developed as an addition to the Connect parenting programme. This was done because parents mentioned a lack of knowledge on social services and their support and functions. The societal information component in the Ladnaan intervention was important for parents' engagement and acceptance of the programme (Study III). The qualitative study (III) revealed that societal information enhanced parents' confidence in parenting, a confidence that could be linked to some of the transitional challenges in the host country. Most of the parents reported that the societal information and knowledge of the family and Child Welfare Services' intervention that was related to out-of-home placement helped to regain their confidence in parenting (Study III). It may be hypothesised that this additional part of the parenting programme supported parents' willingness to accept the programme because it addressed specific needs, an issue not covered in the Connect programme.

Another aspect noted in previous studies is the need to include cultural sensitivity in parenting support programmes for immigrant parents. Cultural sensitivity increases the parents' receptiveness to participate in the parenting programme [104, 113, 119, 123]. Cultural sensitivity had been described in terms of 1) using bilingual and bicultural facilitators, 2) providing the parenting programme to the same ethnic groups, 3) applying culturally sensitive terms [104, 113, 119, 123], 4) the significance of trust between participants and practitioners and 5) culturally sensitive ways of recruiting and retaining parents in the parenting group [104, 113]. Parents who participated in the culturally tailored parenting programme (Study III) reported that the specific needs and cultural sensitivity had a valuable function in their engagement and acceptability of the programme. The parents felt that a parenting support programme in their native language by culturally competent and well-educated group leaders was significant for their participation. A systematic review [150] reported several aspects that were important and increased parents' participation and retention in the parenting programmes: trusted and known people who recruited and delivered the parenting programme, the content of the programme that was tailored to the parents' needs, enhanced their ability to parent and supported their personal development [150]. The use of

metaphors and proverbs in the intervention was a communicative strategy that helped to increase retention of the information and made the content more comprehensible.

In summary, Ochocka et al.'s framework would seem to be helpful guide to frame and develop a parenting support programme for immigrant parents, but the framework lacks some aspects that are important to consider when developing and implementing a culturally tailored parenting support programme. The findings suggest that the roadmap to successfully tailor a parenting support programme for immigrant parents needs to consider acculturation and contextual factors. If the parents have other stressors, they may be reluctant to take part in the programme or drop out of the programme early [109, 150]. A second consideration is the importance of cultural sensitivity in the Ladnaan intervention, an issue that many preventive programmes fail to address. The cultural sensitivity that we identified includes providing the intervention in the native language of the participants by facilitators who are context and culturally competent. Another factor to consider is the use of culturally sensitive terms. These might contribute to feelings of inclusion, whereby the immigrants integrate into the host country while still maintaining a sense of their own cultural identity [33].

There was one area of support in the Ochocka et al. framework [2] that was not covered in the intervention (*facilitate the integration process between newcomers and the native population*). However, in an unpublished study, parents who were given the intervention stated it was important to receive their specific need of support concerning knowledge about the parenting system in the country since they perceived that native Swedish parents already had that knowledge. They thought after gaining knowledge on the parenting system in the host country that they might be at a similar level as native Swedish parents and therefore could participate in a mixed parenting programme on equal terms.

7.4 METHODOLOGICAL CONSIDERATIONS

The present thesis used both explorative studies (qualitative) and a RCT. The qualitative explorative studies helped in understanding the participants' experiences, their context and the circumstances of being a parent in the new home country. Such explorative studies also were helpful in gaining a fuller understanding of the parents' experiences of participating in a programme that was tailored to their individual needs. The RCT contributed to revealing the effectiveness of an intervention that is tailored and delivered to an immigrant group. The design of Study (I) allowed to explore the main challenges that Somali parents encountered in the host country and the need for parenting support. From the RCT, we learned how such parenting support programmes can be tailored and implemented to immigrants in similar settings. However, when conducting and implementing such complex interventions in a real-life setting, there are both methodological strengths and limitations that need to be addressed.

7.4.1 Strengths and limitations of the qualitative studies

The main strengths of the qualitative studies are that trustworthiness was ensured through different data collection methods (FGD in Study I and individual interviews in Study III), conducting interviews in participants' native language and analysing the data through

triangulation (Study III). The credibility of the studies was ensured through interviews with both men and women. In Study I, two of four FGDs were conducted in mixed groups (mothers and fathers), along with one of only fathers and one of only mothers. This arrangement allowed us to explore whether there were any different views between mothers and fathers concerning parenting and need of support. However, we did not identify any sex differences in responses. This strategy of having interviews in a mixed and non-mixed setting allowed us to later conduct the intervention in mixed groups, which the parents preferred. Credibility was also assured by gathering data from 52 of the 60 participants in the intervention group (study III). Thus, there would be a greater possibility of collecting data from a wide range of participants (e.g., those quite new to the country and those who had been living for a longer period). Conducting interviews in the participants' native language ensured that we captured the nuances and various meanings of the language without losing anything in the translation and thus confirmed the credibility of the study. In Study I, both the moderator and the observer met after each interview to discuss and compare notes during the FGD. Another strategy to ensure credibility and conformability was the discussion and dialogue that were carried out between the co-authors throughout data collection, analysis and interpretation. The findings were also presented to the participants, which also contributed to both credibility and conformability of the studies.

A potential limitation is that the participants consciously or subconsciously act in a way they think the researcher want them to act. However, in Study I, the data were collected through FGDs and participants discussed in a group with each other and not with the researcher. We believe that this might reduce this potential limitation. In Study III, participants were interviewed 2 months after they finished the parenting programme. They were also asked for any valuable information they could contribute to the future implementation of the parenting programme with other groups. These actions might help reduce this potential limitation. However, asking parents about what they experienced as most valuable in the intervention might influence which aspects they bring up during the interviews (i.e. positive aspects related to the intervention) and that the less positive experiences were never captured in the interviews. Another potential limitation, but also a strength, is the researcher's insider and outsider perspectives, which may have influenced the process of data collection, analysis and interpretation of the data. Throughout the process of data collection, the first author carried out data analysis and the interpretation of field notes. In addition, the first author wrote in a logbook her comments and reflections about the study, which were then discussed at length with the research team. The researcher's positioning in relation to the context and people studied is discussed in the pre-understanding and reflexivity section.

In study (I), transcribed interviews in Somali were translated into English and the data were analysed through the English transcriptions. Although the transcribed data were crosschecked by the first author and an independent professional translator, purpose of the words and meanings sometimes lacked. However, this problem was minimised by cross checking with the original transcript and audio recordings. In study III, the nuances of the language could be captured by starting the analysis with the original language (i.e. Somali), and thereafter

condensing the codes into words or sentences translated into English. However, some words were difficult to translate and in these cases words or sentences that captured the meaning and experiences were used. This process was also cross checked with one independent bilingual health staff with experience in research, which enhanced the credibility. The findings from the studies were presented to some of the informants and discussed between all authors, which contributed to credibility and confirmability.

7.4.2 Strengths and limitations of the quantitative study

Recruiting and retaining immigrant and ethnic minority groups had been reported to be a major challenge [109, 112, 151]. High attrition rates can reduce the statistical power and threats the internal validity of the study [131, 151]. The main strengths of the RCT study are the high retention (90%) and low dropout rate at the follow-up. At baseline, we had complete data for the intervention and control group. Two participants in the intervention group did not start the parenting programme because of illness or time constraints. At follow-up, three participants (two were participants who did not receive the intervention) in the intervention group and eight in the control group were lost to follow-up. An intention-to-treat analysis was performed that included all randomised parents in the groups to which they were allocated, regardless of the number of sessions in which they participated, if data were available for follow-up. Although we tried to follow-up all randomised participants, three parents could not be reached, of which two did not receive the intervention. However, we could have imputed the baseline data (i.e. loss to follow-up individuals) to missing data at follow-up, assuming that they did not change at follow-up [87].

Another strength of the RCT study is that it included more fathers compared to other studies. Additionally, the guidelines for the data collection process and weekly meetings with research assistants decreased potential bias and error. All data collection was carried out in the participants' native language and most of the data were collected through face-to-face interviews and in the homes of the participants.

The instruments used in the studies had good validity and reliability. Moreover, the instruments could be used in a cross-cultural context. However, during the translation process, several words were difficult to translate directly to Somali, and the developer suggested we use synonyms instead of giving participants suggestions for similar words. A limitation is that the tools were not tested for validity and reliability for this population and in the new context. However, Cronbach's alpha coefficients for all scales was tested and showed good internal reliability. One strength is that all the instruments were translated systematically following the process of translation and they were pilot tested. Likert-type scale response instruments were used, which confused some of the participants. However, this problem was overcome by explaining the different Likert scales to the participants, as most of the data were collected through face-to-face interviews. Therefore, when using these tools, it is important to conduct face-to-face interviews. However, one way to reduce errors from occurring would be to use three Likert scales as with some variables in the CBCL, or dichotomise (yes/no or agree/disagree).

To avoid selection bias (internal and external validity), randomisation was carried out through a computer-generated random number list and each participant chose one of the sealed opaque envelopes in which was written the allocation and number of participants. All participants were allocated randomly to either the intervention or the control group. Randomisation was performed after the baseline data were collected. Participants who were randomly assigned to the control group knew that they would receive the intervention after the follow-up data were collected. Having this information, may have minimised the dropout rate.

The main limitation of the study is that the children's outcomes were based on parental reports, and hence there is the potential risk of bias and lack of objectivity in the parents' responses. It is desirable to collect data from parents, children and teachers. A previous study showed that the responses of mothers and fathers on children's behaviour differed: mothers reported more behavioural problems in children than fathers [152]. Studies that collected data from mothers and teachers showed that while mothers' responses indicated that the intervention had reduced children's behaviour problems immediately after the intervention, teachers' responses indicated an increase in externalising behaviour problems [114]. Our RCT study was initially designed with the intention of collecting data from the parents and the target child. However, the majority of the participating parents refused to give informed consent for their children. Data were only collected from 64 children at baseline and 28 at follow-up, but these data were not included in the results. Another limitation is that when using a self-report measure of parents' outcomes, the participants may underestimate their mental health and overestimate their parenting sense of competence. There are several advantages in using self-reports, namely that they require fewer resources and are easily administered.

An internal validity threat may be a potential risk if the intervention group did not receive the treatment as was intended (i.e. fidelity of the intervention). To avoid this problem, the group leaders participated in the Connect training course by external Connect instructors. Each session of the parenting programme was recorded by the two group leaders and Connect instructors supervised the group leaders after each session based on the video recording to assure the group leaders delivered the material according to the intervention manual. Process evaluation data were collected but not included in the thesis.

An important aspect to discuss methodologically that might be a threat to internal validity is why the intervention worked. What was the mechanism behind the change in children's behaviour and parents' mental health? Could that just be explained by simply meeting and discussing parental issues with other parents? Mediation and clinically meaningful analyses were conducted. These analyses suggest that the intervention influenced the children's behaviour and parents' mental health. The clinical significance test revealed that the mental health of many of the children and parents in the control group deteriorated and that the parents' sense of competence was reduced. The qualitative study (III) confirms that the

parenting skills and confidence of the parents had improved because of taking part in the intervention.

Diffusion of treatment or social interaction treatment occurs when participants in the intervention and control group communicate with each other, which can influence the outcome of both groups [131]. In the present study, we could not keep the groups separated from each other in that they live in one municipality. In the interview study (III), there was one question to cross check whether parents in the intervention group communicated with parents in the control group or other parents in general. All parents responded that they did not talk about their experiences with other parents. However, some suggested that other parents should take a part in the study. Another diffusion of treatment can be that the group leaders communicated with the parents in the control group. However, before the intervention started, the group leaders were instructed not to discuss the study with other parents in the municipality during the study period.

A major threat to internal validity is researcher allegiance, which has been defined as “*a researcher’s belief in the superiority of a treatment and in the superior validity of the theory of change that is associated with the treatment*” [153, p.55]. Another risk related to researcher allegiance is the impact of programme developers as evaluators [154], which sometimes might lead to positive outcomes. However, the intervention in this thesis, the Connect parenting programme that consisted 10 of 12 sessions, is an evidence-based parenting programme that was not developed by the research group. The societal information sessions were developed by the research group in conjunction with professionals from the Family and Child Welfare Service in the municipality and key persons from several Somali Associations. However, this additional part comprised 2 of 12 sessions and addressed important needs that helped to support the parents. Still, these sessions might not be effective *per se*. It would have been desirable if the RCT was designed as a three-arm RCT to determine whether the societal information sessions had impacted the mental health of parents and children.

Approximately 50% of the data were collected by the first author. It could be possible that the participants were eager to give positive views of the parenting programme to please the first author (researcher). However, the first author did not take part in delivering the intervention. It would have been desirable to cross check to determine whether the parents’ responses differed between the first author and the research assistants.

A further limitation is the short-term follow-up (i.e. 2 months). With such a short follow-up, it is difficult to determine whether there are long-term effects of the parenting programme on the mental health of the parents and children, and the parents’ sense of competence in parenting. The parents in the control group were promised to receive the intervention after the follow-up data were collected from both the intervention and control groups. It felt unethical to let the parents wait for a longer period before they were enrolled in the intervention programme. Furthermore, the municipality was resolved that the parenting support programme should be given to the parents in the control group as soon as

the 2-month follow-up data were collected. However, a national study conducted in Sweden demonstrated that the Connect parenting programme had improved children's behavioural and emotional problems 2 years after the intervention [89]. Thus, we believe that the improvement might continue for both parents and children for the long run. Nevertheless, a 2-year long-term follow-up is planned with the aim to evaluate the long-term effects on children's behaviour problems and parents' mental health and sense of competence in parenting.

The results from this thesis are limited to Somali parents living in one municipality in Sweden. The family policies in Sweden differ from other countries and Sweden is known as a social welfare state in which the state subsidises different benefits. The current results might not reflect the results from other countries in which parenting support programmes are paid by the participants. However, the results can be generalised to Somali-born parents who perceive stress in their parenting and an acculturation gap between them and their children. The culturally tailored model applied in this study can be also generalised to other immigrant groups who have experienced war, social or environmental conflicts and to hard-to-reach groups.

7.5 PRE-UNDERSTANDING AND REFLEXIVITY

Reflexivity and the researcher's pre-understanding are crucial factors in all research processes and outcomes, and not only when conducting qualitative studies. This is because our pre-understanding can influence how we formulate research questions, which questions we choose for our data collection, and the conclusions and interpretations we formulate.

Reflexivity does not only contribute to an awareness of our thinking and how it materialised but also to the knowledge we produce. For the purpose of this thesis, I adopted Berger's [155, p.220] explanation on reflexivity in research: "Reflexivity means turning the researcher's lens back onto oneself and the effect that it may have on the setting and people studied, questions being asked, data being collected and its interpretation". By this, Berger [155] means that the personal characteristics of the researcher, such as sex, race, age, language/dialect, education, immigration status, beliefs and ideological, political and religious preferences could have an impact on how the researcher positions her or himself. The researcher's position also affects how she or he gains access to the field, how much information the respondents share with the researcher, and how the researcher constructs the worldview, the use of language and making meaning of the respondents' information.

How was my journey as an insider-outsider researcher? First, let me position myself in relation to the context and on the people I was studying.

There are some similarities and differences between the participants and myself that might have influenced my position as an insider-outsider. On the one hand, I share several characteristics with the participants, including ethnicity, culture, religion, migration and acculturation experiences and being a parent; on the other hand, I have been in Sweden longer and have a higher education than most of the participants.

Sharing experiences with the study participants contributed to my positioning as an ‘insider’ and gave me the opportunity to gain access to the community. However, for several reasons, I had the role of an ‘outsider’ in the beginning. I was representing a research study that was a collaboration between the university and social services, the latter of which the study participants feared because of their perception of child protection policies. I was also performing research on parenting support, mental health and immigration, which, to some extent, involves sensitivity. For these reasons, I needed to gain both the trust of, and access to, the community. This access was facilitated by meetings with key individuals, Somali associations and working with Somali professionals within the municipality. Moving from outsider to insider was an ongoing process, and I was continually moving from outsider to insider with every contact. Sharing the same experiences and challenges as the study participants facilitated the recruitment of the participants and entering their world with some knowledge. I held both the insider and the outsider role at the same time.

My previous experience on migration and personal characteristics had some impact on the research process, such as recruitment and collecting and analysing data. I also knew and sensed intuitively and culturally when it was okay to ask certain questions and when it was not. One might wonder that my role as an insider might have prevented me from asking crucial questions to the study participants, but what I mean is that it is about being culturally and context sensitive: *what to say, how to say it and when to say it*. For instance, our screening protocol, which we carefully devised beforehand, had one question that was important for the inclusion criteria: *Are you stressed about your parenting?* Most of the parents answered *No*, but when I asked the second screening question, *Do you need support for your parenting?* the same parents said *Yes*. I intuitively understood that it was a matter of how I asked the question and not the question itself. Thus, I re-formulated the screening question to: *Are you stressed and worried about your parenting since you came to Sweden?* This simple re-wording made a difference in how parents answered.

During the qualitative data collection, some of the participants would say *You know why* or often they did not finish the sentences, i.e. they assumed that I knew what they were talking/thinking about. Even if I (thought I) knew what they meant, I asked them to tell me about it. Asking for clarification and not merely agreeing with them was motivated by my previous experiences on conducting interviews, putting on my research lens and balancing my insider-outsider perspectives in the research study. When I was analysing the qualitative data, it required constant awareness of what was my voice along with their voices in my head, so that I do not transpose my experiences as their experiences. However, the analysing process differed from the data collection process. In the analysing process, my supervisors, who did not share the same experiences as the participants, constantly challenged me when we were discussing the codes, sub-categories and categories. Particularly with my first paper, I have been forced to recognise my pre-understanding. Accordingly, my supervisors and I discussed the analysis until we came to a consensus. However, my pre-understanding was important to make sense of the data and identify the codes and categories.

8 CONCLUSION

The present findings indicate that the process of acculturation and transition in the host country impacted on the parents' mental health and their parenting. The experience of acculturation stress not only affected the parents but also parenting practices and the parent-child relationship. The acculturation gap between parents and children led to role changes and power conflicts. The parents experienced fear of the social services and mutual mistrust between them and the social services and schools. The parents suggested a specific need to focus on societal information and strengthening the parent-child relationship.

The cultural sensitivity aspects of the parenting support programme played a vital role in the parents' acceptance of the programme. This shows the importance of developing and tailoring parenting support programmes to immigrant parents' needs as well as delivering it in their native language, which thus contributes to accessibility of parenting support programmes to immigrant parents. Our findings also revealed that the programme markedly improved the clinical mental health of the parents and children as well as the parents' sense of competence in parenting. It was further found that the increased satisfaction in parenting could partially be explained by the improvements in parents' mental health. However, in this work we could not determine the underlying mechanism(s) for the decreased externalising problems in children.

The combination of the culturally tailored parenting support programme of societal information and the Connect programme was supportive for Somali parents in their parenting. Of the Ladnaan intervention, there were two sessions of societal information and six sessions of the Connect parenting programme that parents experienced to be most valuable. The societal information contributed to enhancing the parents' confidence in parenting while the Connect programme contributed to the parents' emotional awareness and availability for their child. In conclusion, the participants' specific needs and the cultural sensitivity aspects of the parenting support programme contributed to Somali-born parents' engagement and retention in the parenting programme. Moreover, it led to a positive outcome on the children's behavioural problems, parents' mental health and sense of competence in parenting, and reduced many of the parenting challenges faced by immigrant parents when making the difficult transition to the host country

8.1 IMPLICATIONS FOR PRACTISE

This thesis suggests that a culturally tailored parenting support programme prepares immigrant parents to modify their parenting orientation and styles to the new country, improves the parents' mental health, sense of competence in parenting and children's behaviour problems.

A roadmap to a culturally tailored parenting support programme is important when developing, engaging and retaining immigrant parents in parenting support programmes.

The findings clearly show the need for societal information to facilitate family acculturation challenges. The present findings suggest that immigrant parents continuously receive societal information from the municipality about the new country and its parenting and support systems. The Somali parents stated that most of the information they had received at the introductory for newly arrived immigrants was irrelevant at the time they were given the information. The introductory information was most likely relevant, but the parents received it when they were new to the country and had other acculturative stressors and therefore might not have been receptive to taking in the new information. Providing the parents information about their responsibility and rights as parents in the new country as well as the rights of their children can serve to empower their parenting and facilitate some of the challenges they will face during the transition period in the host country. The parents also pointed out that the children need to obtain information about the host country and family system, which is an issue requiring further investigation.

When tailoring a parenting support programme, it is important to meet the individual needs of the target population. This means addressing the acculturation stressors and complement with a regular programme that appeals to their unique needs. For instance, Somali parents wanted a parenting programme that would strengthen the parent-child relationship. Other immigrant parents might need a parenting programme designed to prevent child behaviour problems. Another important issue to address when implementing a culturally tailored parenting programme is the cultural sensitivity in the delivering approach. Delivering a parenting programme in participants' native language may play a crucial role in their acceptance of the programme. However, this can sometimes be difficult due to limited resources or lack of people able to deliver such a programme. The findings of this thesis can help provide guidance in identifying ways to engage and attract immigrant parents to parenting support programmes. These programmes need to consider that immigrant parents may have different starting points in their parenting support needs depending on how long they have been in the country and their acculturation process. Therefore, it is important to tailor to the needs of the parents and not assume what their needs are. This thesis enrolled more fathers compared with other studies. To attract both mothers and fathers to participate in the parenting programme, group leaders of both sexes should be trained to deliver the programme. Moreover, it is important to have a facilitative approach so that potential practicalities (e.g., babysitting, transportation) that may hinder parents to attend parenting programmes are addressed.

Parental support is beneficial and highly important in preventing or reducing children's behaviour problems. Moreover, it improves parents' sense of competence and parenting skills. Therefore, it is crucial that such interventions are assured through sustainable funding; otherwise, it will risk being only a short-term investment.

Additional implications of this thesis are that professionals in social services require more knowledge and training in the importance of pre-migration, migration and post-migration factors on families, as well as the acculturation gap's that may influence parent-child relationships. Most important is not to interpret acculturation gaps between parents and

children as an inability of the parents to care for their children or solely as cultural problems. Appropriate training can improve the cultural competences of professionals and associated services targeting immigrant families; and can help engage difficult-to-reach parents, thereby strengthening their parenting practices.

8.2 FUTURE RESEARCH

This thesis was an attempt to develop, implement and evaluate a culturally tailored parenting programme. The studies both answer and raise several questions to consider for future studies. There is a need for a long-term evaluation of the effectiveness on the mental health of children and parents and parents' sense of competence in parenting. There is also a need to investigate the cost-effectiveness and cost-benefits of parenting programmes. This information might contribute to the parents and children's gain or decline in health and quality of life as well as guide resource allocation decisions for such parenting programmes. Moreover, there is a need to include the evaluation of such programmes from the child and teacher's perspective.

In this thesis, the additional sessions in the parenting programme (i.e. the two sessions of societal information) were developed through Somali parents' experiences and needs in their parenting in the new country. It is desirable to also investigate from the children's perspective on how they manage their lives in the host country and their needs to promote their mental health and reduce the acculturation conflicts between the parent and child.

Over half of the participants had been living in Sweden less than 6 years. Somali parents who have lived in Sweden a much longer time might have different experiences and needs. For instance, those living a long time in the host country might not need to have the parenting programme in their native language and instead would prefer to participate in the universal parenting programmes through municipalities, schools and primary care. Therefore, research should be undertaken to examine their experiences and needs. Furthermore, it is important to investigate how immigrant parents and their children who have lived in the host country for a longer period negotiate autonomy, which might influence parent-child conflicts.

One aspect that the participants mentioned in study I was the importance of a social network and that such a network is absent in the new country. Research is needed concerning how the neighbourhood and civil society can be resourceful in smoothing the way for the immigrants' transition to life in the new country. This knowledge might facilitate the integration or inclusion of newly arrived immigrants into the native population.

Several studies have reported migration effects on immigrants' mental health. However, it is important to investigate how socioeconomic vulnerability affects family dynamics, parent-child relationships and the mental health of parents and children.

9 SAMMANFATTNING (IN SWEDISH)

Bakgrund: Forskning visar att migration till ett annat land kan innebära en rad utmaningar såsom ackulturation, isolering och brist på socialt stöd för föräldrar som har migrerat från länder med annan kultur än det nya hemlandet. Dessa utmaningar visar sig ha effekt på hur familjen fungerar i det nya landet, familjens emotionella och mentala hälsa, föräldraskapet samt föräldrarnas tilltro till sin egen föräldraförmåga. Föräldrastödsprogram har visat ha goda effekter på att förbättra föräldraförmåga, psykiska hälsa hos föräldrar och barn samt stärka föräldra-barn relationen. Dock, finns det svårigheter att nå och behålla utlandsfödda föräldrar i universella föräldrastödsprogrammen. Dessutom finns det begränsad kunskap om effekten på föräldrastödsprogrammen hos Somaliska-födda föräldrar och deras barn.

Syfte: Det övergripande syftet med föreliggande avhandling var att utveckla och utvärdera effekten av ett kulturanpassat föräldrastödsprogram (Ladnaan intervention) avseende psykiska hälsa hos Somalisk-födda föräldrar och deras barn. Vidare var syftet att undersöka föräldrarnas erfarenheter av programmet och dess påverkan på deras föräldraskap.

Metod: Avhandlingen består av två explorativa studier och en randomiserad kontrollerad studie. I **studie I**, genomfördes kvalitativ fokusgruppsdiskussioner för att undersöka Somalisk-födda föräldrars behov av föräldrastöd. I **studie II**, genomfördes en randomiserad kontrollerad studie, där 120 föräldrar med barn i åldrarna 11-16 år och med självrapporterad stress i föräldraskapet, lottades till en interventionsgrupp eller till en kontrollgrupp (väntelistedesign). Ladnaan interventionen bestod av tre komponenter: samhällsinformation (två träffar), Connect program (10 träffar) och kultur sensitivitets komponent där interventionen gavs på deras hemspråk av gruppledare med somaliskt ursprung, samt modifiering av exemplen och rollspelen i Connect programmet. Det primära utfallet var minskning av emotionella- och beteende problem hos barnen, vilket mättes av instrumentet Child Behaviour Checklist 6-18 (CBCL). Det sekundära utfallet var förbättrad psykisk hälsa hos föräldrar som mättes med instrumentet General Health Questionnaire (GHQ12), samt föräldrarnas tilltro och kompetensförmåga i föräldraskapet som mättes av instrumentet Parents Sense of Competence (PSOC). I **studie III**, genomfördes kvalitativa individuella intervjuer två månader efter interventionen, för att undersöka föräldrarnas erfarenheter av att ha erbjudits Ladnaan-interventionen som består av ett kulturanpassat föräldrastödsprogram.

Resultat: Resultatet i **studie I** visade att Somalisk-födda föräldrar mötte utmaningar i det nya landet som hade påverkan på deras tilltro till föräldraskapet samt föräldra-barn relationen. De utmaningar som de beskrev var bland annat bristfällig information om samhällets förväntningar på föräldrarollen i det nya landet. Andra utmaningar var en upplevd stressig livssituation, isolering, samt rollförändringar och maktkonflikter mellan föräldrarna och mellan föräldrar och barn. Trots detta upplevde Somaliska föräldrar det som en möjlighet att ompröva och modifiera sitt föräldraskap, samt stärka relationen med sina barn i det nya landet. Dock, efterfrågade föräldrarna stöd i deras föräldraskap. Resultaten i **studie II**, visade att Ladnaan interventionen signifikant minskade barnens aggressiva beteende, sociala problem, uppmärksamhetsproblem, utåtagerande problem samt totala problemen två månader

efter interventionen. Vidare visade resultaten att föräldrarna i interventionsgruppen hade förbättrad psykiska hälsa, samt tilltro till sin egen föräldraskapskompetens, två månader efter interventionen. Föräldrarnas förbättrade psykiska hälsa kunde delvis förklara deras nöjdhet i föräldraskapet efter interventionen. I studie III, rapporterade föräldrar i interventionsgruppen rapporterade att den första komponenten i Ladnaan interventionen samhällsinformationen förbättrade deras tilltro i föräldraskapet samt bidrog till deras förmåga att vara känslomässigt medveten och tillgänglig för deras barn. Föräldrarna upplevde att det var kombinationen av samhällsinformationen, Connect programmet samt kultur sensitiviteten i programmet som var mest stödjande för deras föräldraskap. Det kultursensitiva tillvägagångssättet i föräldrastödsprogrammet sågs som värdefullt för deras engagemang och acceptans av föräldrastödsprogrammet.

Konklusion: Det kulturanpassade föräldrastödsprogrammet bidrog till att föräldrarna ökade kunskapen om samhällets förväntningar på föräldrarollen i det nya landet. Det bidrog också till att de modifierade sin föräldraorientering och föräldrastilar. Det kulturanpassade föräldrastödsprogrammet förbättrade föräldrarnas psykiska hälsa samt tilltro och kompetensförmåga i föräldraskapet, även reducerade barnens beteende problem. När föräldrastödsprogram ska erbjudas föräldrar som har migrerat från länder med annan kultur än det nya hemlandet kan det vara betydelsefullt att ta hänsyn till deras specifika behov samt att inkludera kultursensitivitet i programmet. Ett sådant tillvägagångssätt kan öka engagemang, närvaro och acceptans för föräldrastödsprogram bland grupper som annars kan vara svåra att nå med detta stöd.

10 DULMAR KOOBAN (AF-SOOMAALI/ IN SOMALI)

Hordhac: Cilmi baarisyo horay loo sameeyay ayaa muujinaya u qaxida wadan kale in lala kulmo caqabado badan sida dhaqan cusub oo keeni kara isbedel dhaqameed, go'doon iyo taageeridda bulshada oo lunta. Taasoo saameeyn ku yeelato caafimaadka iyo dareenka qoyska, hab-dhaqanka qoyska iyo waalidiinta, kalsoonida iyo ku qanacsanaanta waalidnimada. Barnaamijyada lagu taageero waalidka waxay muujiyeen ineey saameeyn wanaagsan ku yeeshaan dhaqamada waalidka, xoojiyaanna saaxiibtinimada waalidka iyo carruurta, korna ay u qaadaan caafimaadka maskaxda ee waalidka iyo carruurta. Laakiin waxaa jirta caqabado ah sida in barnaamijyada guud ee lagu taageero waalidiinta la gaarsiiyo ama ay ka qeyb galaan si joogta ah waalidiinta soo galootiga ah. Waxaa kaloo jira aqoon xaddidan oo ku saabsan waxtarka barnaamijyada lagu taageero waalidiinta ay u leedahay waalidiinta Soomaalida iyo carruurtooda.

Ujeedo: Ujeedada guud ee cilmi baaristaan waa in la hormariyo lana qiimeeyo waxtarka uu ku leeyahay, barnaamijka taageeridda waalidiinta ee la dhaqan galiyay (Ladnaan), caafimaadka maskaxda ee waalidiinta soomaaliyeed iyo carruurtooda. Waxaa kaloo ay ujeedada tahay in la ogaado in khibradani ay saameeyn ku yeelatay waalidiinta dhinaca waxqabadka iyo hab-dhaqanka waalidnimadooda.

Qaabeyn: Cilmi baaristaan waxay ka kooban tahay labo daraaso oo waraysi ah iyo hal daraasad tijaabo la hubiyay (RCT) ah. **Daraasada 1 aad**, waxaa la sameeyay waraysi falanqeeyn kooxeed ah, iyadoo ujeeddadu ahayd in la ogaado waalidiinta Soomaaliyeed baahida ay u qabaan taageero waalidnimo. **Daraasada 2 aad**, waxaa la sameeyay tijaabo la xakameeyay, iyadoo 120 waalid ah oo leh caruur da'dooda ay u dhaxeeyso 11-16 jir, kana walwalsan waalidnimadooda, loo qeybiyay si qoritur ah kooxna waxbarashada la siiyay iyo kooxna sugida ee xakamaha. Waxqabadka loogu magacdaray Ladnaan, wuxuu ka koobnaa: warbixin ku saabsan adeegga bulshada (labo kulan), barnaamijka Connect (10 kulan) iyo habdhaqameed ku salaysan inuu ku baxo luqaddooda hooyo, ay bixiyaan macallimiin isku waddan iyo isku dhaqan ah iyo in tusaalooyinka la waafajiyo mid ay fahmayaan. Natiijada hore waxay ahayd in ay yaraato ama hoos u dhacdo dhibaatooyinka hab-dhaqanka iyo dabeecada carruurta, iyadoo lagu cabiray su'aalaha Liiska Warbixinta Hab-dhaqanka Carruurta (Child Behaviour Checklist 6-18). Natiijada labaadna waxay ahayd in ay wanaajiso caafimaadka maskaxda ee waalidka, iyadoo lagu cabiray Su'aalaha Caafimaadka Guud (General health Questionnaire-12), iyo in ay wanaajiso kalsoonida iyo ku qanacsanaanta waalidnimada, iyadoo lagu cabiray su'aalaha Aqoonta Kartida Waalidka (Parent Sense of Competence). **Daraasada 3 aad**, waxaa la sameeyay waraysi keli-keli ah, iyadoo ujeeddadu ahayd in la ogaado khibradda waalidiinta ka heleen ka qeyb galka ay ka qeyb galeen waxqabadka Ladnaan.

Natiijooyinka: Natiijada **daraasada 1 aad**, ayaa muujisay in waalidiinta Soomaaliyeed ay kala kulmeen caqabado badan waddanka cusub ee ay yimaadeen, taasoo saameeyn ku yeelatay waalidnimadooda iyo xiriirka waalidka iyo carruurta. Caqabadahaas waxaa ka mid ah in aanay lahayn aqoon ku filan oo ku saabsan nidaamka waalidnimada iyo waajibaadka

waddanka cusub. Caqabadaha kale oo waalidiinta ka hor yimid waxaa ka mid ah walaac dhinaca bulshada, go'doon, isbedel doorka waalidka iyo carruurta, iyo awood isku-dhac waalidka iyo carruurta. Waalidiinta Soomaaliyeed waxay la kulmeen fursad ay dib uga fikiraaan waxna uga baddalaan hab-dhaqanka waalidnimadooda, iyo xoojinta xiriirka ay la leeyihiin carruurtooda waddanka cusub, laakiin ay u baahan yihiin taageero bulshada deegaanka (adeegyada bulshada) iyo kuwa kaleba oo dadaalka taageeridda waalidiinta ka jira.

Daraasada 2 aad, barnaamijka taageeridda waalidiinta oo la dhaqameeyay wuxuu muujiyay (wareysi waalidiinta laga wareystay carruurtooda), in carruurta waxqabadka waalidkooda la siiyay ay aad hoos u dhacday dabeecadda garddarada ah, dhibaatooyinka hab-dhaqanka bulshada, dhibaatooyinka foajignaanta, dhibaatooyinka iyo dabeecadda kulul uu ilmaha la yimaado, iyo dhibaatooyinka guud labo bilood kaddib. Sidoo kale, waalidiinta wax qabadka la siiyay aad ayuu u wanaagsanaaday caafimaadka maskaxdooda iyo kalsoonida iyo ku qanacsanaanta waalidnimadooda labo bilood kaddib markii uu u dhamaaday wax qabadka. Wanaagsanaanta (hagaaga) caafimaadka maskaxda ee waalidka ayaa qeyb ahaan lagu sharaxi karaa inuu ka yimaaday ku qanacsanaanta waalidnimadooda.

Daraasada 3 aad, waalidka ka qeyb galay waxqabadka ayaa sheegay in barnaamijka taageeridda waalidnimada ee la dhaqameeyay kobciyay kalsoonida waalidnimadooda, wuxuu kaloo u kordhiyay in ay dareenkooda iyo dhagahooda u raariciyaan carruurtooda. Waalidiinta waxay kaloo sheegeen in isku darka macluumaadka bulshada, barnaamijka Connect iyo dhaqanka la raaciyay waxqabadka ay ahaayeen kuwa aad u taageera waalidnimadooda. Hab-dhaqameedka la raaciyay barnaamijka taageeridda waalidka sida inuu ku baxo barnaamijka luqaddooda hooyo, ayna bixiyaan dad ay isku waddan iyo dhaqan yihiin, waxay u arkeen mid qiimo wayn u leh, kuna lug lahayd aqbalaada barnaamijka.

Gaba gabadii: Barnaamijka taageeridda waalidiinta ee la dhaqameeyay (Ladnaan) ayaa ka caawiyay waalidiinta ineey ka gudbaan caqabadaha ay kala kulmeen wadanka cusub dhinaca walidnimadooda, iyo ineey wax ka badalaan hab-dhaqanka waalidnimadooda. Sidoo kale, wuxuu barnaamijkan wanaajiyay caafimaadka maskaxda waalidiinta, kalsoonida iyo ku qanacsanaanta waalidnimadooda, iyo inuu yareeyay dhibaatooyinka hab-dhaqanka carruurta. Marka loo gudbinayo barnaamijka taageeridda waalidiinta dhaqamada kale leh ama ka yimaada wadamo kale, waa muhiim in la tixgeliyo baahidooda gaarka ah iyo inuu barnaamijku ku baxayo luqaddooda, ayna bixinayaan dad ay isku luqad iyo dhaqan yihiin. Nidaamka noocan ah ayaa suurtagal ah inuu gacan ka gaysto hawl-gelinta, dhaqan-gelinta iyo aqbalaada barnaamijka taageeridda waalidiinta.

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